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ABSTRACT

Defining the role of the homemaker/home health aide, the volume presents a comprehensive treatment of the principles and procedures for recruiting, training, and directing the activities of these essential health workers. In addition to providing an analysis of the contribution that the homemaker/home health aide can make to patient care, the book examines the broad area of home health agency operation in the United States and abroad. The following topics are considered: (1) homemaker/home health aide services, (2) home help abroad, (3) the titles and functions of the homemaker/home health aide, (4) agency policy and services, (5) determining and evaluating areas of need, (6) organization and administration, (7) the pattern of service, (8) recruitment and selection, (9) training plans and methods, (10) the training program: orientation, (11) the development of the core training program, and (12) teaching methods as they relate to: personal care, nutrition, meal planning, food storage, and marketing. A 10-page bibliography emphasizes materials related to organization and management, training, and training materials. (MW)

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Homemaker/Home Health Aide Services in the United States

by Brahna Trager

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Preface

There has been universal agreement within the health care field for several years that alternatives to institutional care are urgently needed, both to contain the spiralling inflation of health care costs and to provide more suitable care for several categories of patients, with emphasis on patients requiring long-term care. Home health care has long been recognized as the most satisfactory of these sought-after alternatives.

The homemaker-home health aide is an indispensable individual in the delivery of home care, and leaders in the home health field have long called for a definitive manual or text book setting forth the principles and procedures for recruiting, training, and directing the activities of these essential health workers. Miss Brahna Trager has, in the present comprehensive treatment of the subject, clearly and effectively responded to this urgent demand for authoritative guidance. She provides us with a complete analysis of the contribution that the homemaker-home health aide can make to patient care, and she also achieves an exceptional presentation of the whole broad area of home health agency operation, both in the United States and abroad.

The Bureau of Community Health Services feels privileged in making available this unique contribution by a distinguished writer and leader in the home health field.

PAUL B. BATALDEN, M.D.
Assistant Surgeon General
Director, Bureau of Community Health Services

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CHAPTER 1

Homemaker/Home Health Aide Services

Homemaker/home health aide services include an array of services in which the homemaker/home health aide is only one component. As the term implies, these services are based in the home. Their objective is to support, maintain or improve the quality of life for families or individuals when health, safety, personal or family integrity are threatened, either by illness of short or long duration, by social or emotional crises, or by combinations of these —and they are frequently found together, since the "quality of life" is usually threatened in all of its aspects by crisis in any single area.

Achievement of this objective depends upon services which are provided within an administrative framework. Homemaker/home health aide services are never casual individual services—although at the point of delivery they are individualized. They require, in addition to an administrative structure, a professional staff with well defined responsibilities. These include capability in the assessment and selection of those situations in which care in the home will be effective; the formulation of sound care plans; the use of appropriate related sources; and the coordination and adaptation of services to meet changing need—in short, all of those professional elements which are essential to any quality treatment program. Added to these is the responsibility which is unique to these services: the selection, training and supervision of homemaker/home health aides, and their placement in the homes of recipients of services with concern for personal compatability and assigned care tasks geared to the achievement of treatment goals.

The activities of the homemaker/home health aide involve more than home management skills or supportive health care. The special feature of these activities is the presence of an intact, warm, healthy personality in intimate contact with the sick or threatened family or individual in the environment of the "home,"—supporting all that the term "home" implies: safety, familiarity, security, and shelter. This is what distinguishes these services from other institutionalized health and welfare programs. Thus, they cannot be seen as a substitute for other community services. They do not replace the foster home, the hospital, or the nursing home. Such

services are effective only when care in the home is appropriate to need and when, within the community and within the service itself, those elements which assure their effectiveness are present. They then become, for both the community and the recipient, a reliable resource in the range of community services which are essential to the delivery of comprehensive health care.

THE COMPREHENSIVE APPROACH TO COMMUNITY PLANNING

In the development of programs for services in the home, a comprehensive approach prevents fragmentation, duplication, and the creation of large gaps through which small people fall because there is no "appropriate" service. It ignores the concept of special programming around the post-hospital patient, the acutely ill short-term patient, the chronically ill patient, or the disabled, retarded, aged or young, socially deprived, emotionally disadvantaged or mentally ill patient—since all of these circumstances may be interrelated and are never static. It also ignores, at the point of service, the isolation of skills, since, from the simplest program of maintenance to the most complex therapeutic regimen, there is a necessary and non-static interrelationship.

The remarkably slow development of services in the home is in itself an expression of fragmentation in thinking and planning. The high degree of professional and technical skill which has produced the best institutions in the world has been expended previously upon what can take place within those walls; where extensions have been tried, they have been viewed with alarm or with the kind of pride accorded a sport in the therapeutic family. Yet, in a comprehensive program, services in the home might well be considered the other half of the treatment complex, as it is conceived of in institutional care; or the other third if we include, as we should, prevention.

Although the need for services in the home can be seen in the failure of innumerable post-hospital plans, in the extension of unnecessary acute hospital care as a substitute, in the acknowledged occupancy of chronic disease and nursing home beds by those who do not belong in them, in the punishing effects of inappropriate institutionalization on children and in the isolated deterioration of the aged and disabled, there has been surprisingly little development of such services compared with the advances in institutional care. The possibilities of organized home care programs, homemaker/home health aide services, and a host of similar extensions of preventive, therapeutic and supportive services into the home have been described, applauded—and then

neglected. Rather than evidence of indifference, this neglect might more accurately reflect lack of understanding and absence of those basic structural necessities in community organization which are essential to the success of such programs. The lack of understanding and, as a consequence, of community development, might be attributed to a variety of causes.

Common Misconceptions

The idea that services in the home are a substitute for something else is a misconception. They have been seen as a way of saving institutional beds, an economy measure, a method of utilizing sources of funds not otherwise available and as evidence that the community or institution has adopted a current fashionable stance.

Programs which rely upon such considerations have not served these or any other community needs well. It is true that without the development of services in the home, institutional resources must be misused or unrealistically developed: however, it is equally true that the misuse of homemaker/home health aide programs compounds the problems which they are intended to cure. Where they have been used inappropriately, the results have been discouraging; where they have been "skewed" to satisfy funding requirements or developed as an isolated community "show piece" in the service range—in short, where clear purpose has not inspired good planning—they have not demonstrated their usefulness. Homemaker/home health aide services can be effective only when they are considered as one of the necessary components in the delivery of good care, to be used appropriately as a part of a continuum and related to a whole program of services.

It is virtually impossible to provide services in the home unless the professional skills necessary to support and maintain them are available and are functionally linked to them. At its best, such a program relies on medical, nursing, public health, and social services. It also relies on a recognition of the rights of patients to an environment in which the essentials for health and personal security have been as carefully considered in the context of the home as they have in the institution. If the fundamental relationship of home care to essential services has not been seriously accepted, the necessary framework is either absent or expressed with a superficiality that is a nod to appearances.

Misunderstandings concerning potential sources of manpower are related to the idea that services of quality must be provided by professionally trained persons, particularly when these services are delivered in the home, where the opportunity for independent action may endanger effective support of the thera-

peutic plan. However, effective programs have recruited, trained, placed and supervised workers who had previously been unskilled, who often had no previous work history and who often lacked some of the conventional attributes which have been considered essential. The services provided by these programs have been of good quality and have achieved their stated objectives: they have provided a safe, therapeutic environment for those who might—for lack of simple but essential care—have required institutional care. "Effective programs" are those which provide safeguards in the processes of recruitment, training, placement and supervision of non-professional workers that ensure safe, paraprofessional performance.

That aspect of homemaker/home health aide service which is concerned with the maintenance of a decent environment—the "housekeeping" activities—has obscured recognition of the value of the total range of services provided, and of their potential in the protection of human resources. "Housekeeping" does not appear to demand professional attention, does not seem to justify organized services, and does not merit assumption of the financial burden of sound home care plans. "Housekeepers" are usually seen as domestics, or day workers; they can be picked up off the bulletin board in the supermarket, out of the public employment service, or in the home of a neighbor.

"Housekeeping" services are a part of the per diem cost in every hospital, nursing home and child-care institution, and are paid for as a matter of course. They are essential because institutional therapies could not be effective without them; and they are as carefully integrated in the institutional setting as any other aspect of care. They are just as essential in the home and must be as effectively planned and integrated into the total treatment program. Agencies providing in-home services which have attempted to diminish or eliminate environmental services in an effort to overcome this obstacle to community understanding have experienced a corresponding reduction in service effectiveness and utilization. "Housekeeping" remains an integral part of personal need, in *and* out of institutions, whenever supportive and/or therapeutic help are necessary.

Personal care skills—those activities which involve direct services to individuals who require such care because of illness or disability—have been another source of misunderstanding.

Personal care services which are provided safely by paraprofessionals in institutions can be provided by homemaker/home health aides with equal safety in the home—as has been proven by functioning programs in the United States and in the well developed European programs. The safeguards rest upon good training,

careful professional supervision, and a clear delineation of those tasks which can be safely performed by the individual aide in a given situation and those which can be performed only by a professional.

The price which is paid for failure to understand the potential of the supportive and enabling aspects of homemaker/home health aide services in the United States is a great deal of unnecessary institutional care; misuse of valuable professional time and services; and, most important, the destruction of a personal way of life for many individuals and families who are in need of such services and are forced to accept inappropriate alternatives because these services are not available.

DEVELOPMENT OF HOMEMAKER/HOME HEALTH AIDE SERVICES

The history of homemaker/home health aide services in the United States has been singularly marked by contradiction and paradox. As a culture, we profess unusual interest in the integrity of family life. Yet, for many decades, we have chosen institutional paths for our young, our dependent, our sick, and our aged: paths which stress separation and which undermine security. Unlike other Western cultures, there has been surprisingly little interest in the United States in the development of in-home services as an alternative to institutional care. We profess a determination to provide training and employment for our unskilled potential workers; yet there are few established training programs for dignified employment in a field that has been elevated to a vocation elsewhere in the Western world.

We profess the respect of a pioneer culture for those who work with their hands; yet homemaker/home health aide programs, where they have been developed, frequently pay low wages, offer few guarantees, and require that employees be paid by the hour "as needed," yet remain available for work at all times. Benefits such as sick leave, vacations, pension plans, and protection against unemployment—all taken for granted in other fields—are frequently not available to the homemaker/home health aide. Many of the programs are considered "charitable," and a good deal of that "charity" has been at the expense of the homemaker/home health aide.

We have been continuously concerned with the problem of limited professional manpower in the fields of health care and social welfare; the need for new ways of extending the capability of our professionals has been stressed repeatedly; and we have professed interest in innovative approaches to the delivery of

services. The potential of homemaker/home health aide services as an organized extension of professional services, and of programmed care in the home, have been realized only minimally in relation to the need and our capacity to develop them.

Perhaps we are truest to our cultural conditioning in our reaction to these adversities. Homemaker/home health aide services in the United States have slowly but tenaciously developed in spite of these obstacles. Furthermore, they have evolved in a context in which quality and the standards for quality prevail: the concepts of sound administration; discrimination in the appropriate uses of services; a basic understanding of the need for integrated professional participation; definition of the essential elements in the training of homemaker/home health aides; and most important, the realization that planning and coordination are inseparable from quality services at the point of delivery in the home. In addition, there is probably no professional field within which admiration and respect for the non-professional worker are more solid or deeply felt, based on the recognition of demonstrated excellence.

In retrospect, it is possible to identify those points at which the progression occurred: from the casual use in crisis situations of untrained domestics to the qualified homemaker/home health aide; from the isolated and fragmented home visits of various professionals to a planned interdisciplinary approach; from the narrow view of the usefulness of the services to the broad health-welfare concept; and from the view of the home as an unlikely setting for therapeutic services to the realization that the home can become the setting of choice in the treatment and management of a wide variety of major problems.

In 1959, in Chicago, an impressive group of agencies and individuals was brought together under Federal auspices at a conference which, for the first time, established the potential of homemaker/home health aide services in the broadest possible context. In preparation for this conference, 11 preconference study groups met over a period of six months to discuss significant aspects of the services: administration; community organization; recruitment and training; professional participation; financing; standards for service use in social welfare, mental health; and the developing public and voluntary health care programs (*1*).

At the conference itself, representatives from 26 national voluntary agencies and eight sections of the U.S. Department of Health Education and Welfare worked together to develop a set of 37 recommendations. Many of these are still objectives for the future; but, in their total approach, they established a direction and a frame of reference which lifted the services from the level

of occasional, voluntary or isolated effort to a position of established necessity.

These recommendations included the following:

> "Every community should have . . . services available. In some . . . this will mean several programs, in others several communities may combine and use a single program."
>
> ". . . services may be provided satisfactorily in a variety of settings . . . services may be a part of a broader program to meet the needs of people in their own homes as is the case with public and private family and children's agencies and visiting nurse associations or they may be administered by independent agencies established solely for this purpose. . . . other settings would be equally satisfactory; for example, hospitals . . . and multipurpose homes . . . offering services in the community as a preventive against unnecessary institutional care."
>
> ". . . services should be available to individuals in all economic and age groups."
>
> "Arbitrary limitations on the number of hours, frequency, and periods of time . . . are undesirable."
>
> "Inasmuch as 83 percent of families who received . . . services . . . had an ill member at home and an additional 10 percent had a member in the hospital . . . services should be considered an *integral part of medical care* (emphasis added) . . . as are nursing, medical and psychiatric social work, physical, occupational and speech therapy and other . . . services."
>
> ". . . Services offered on a broad basis, to keep pace with advances in medical, public health and social care, must emphasize cooperative planning . . . with services for the acutely and chronically ill and disabled, the aged, the mentally ill, and the mentally retarded . . . services to these groups will mean refocusing some aspects of current programs and developing new roles and skills for the homemaker" (*2*).

These and recommendations calling for medical direction, interdisciplinary professional participation and the development of guidelines for personal care services—when they are provided by the non-professional service staff—added a new dimension and a significant but relatively new emphasis in the development of homemaker/home health aide services.

Early Services

The first "homemaker" or "visiting housekeeper" programs in the United States were developed in the early 1900's by private

charitable family agencies and were intended primarily to care for young children whose mothers were ill or incapacitated, usually in the then prolonged "confinement" period of pregnancy. This emphasis on child care continued until the depression years, when the search for employment opportunities stimulated the development of "housekeeper projects" which were government funded and placed in emergency relief programs. The emphasis in these projects was primarily on jobs; and this emphasis may have interfered with the development of ongoing community services. Assignments were made almost exclusively in the families of relief recipients; and in this pattern of the poor helping the poor—with virtually nothing in the way of resources—there may have been little of outstanding value to demonstrate to the community at large. Although we hear occasionally about the "fine housekeeping services" of WPA days, they were not sustained. The quiet development of quality services continued in private agencies and were still dedicated to child care and family life.

Between 1903, the date of the first home help (four "visiting cleaners" employed by the Family Service Bureau of New York City to supplement nursing services to sick mothers at home) and 1958, when a national survey of homemaker agencies was made, the number of agencies in the United States providing such services grew to 143, and the number of homemakers employed (both part- and full-time to 1,715 (*3*). (In contrast, Finland, in 1957, with a population of 4,200,000—2½ percent of ours—employed over 1,000 full-time homemakers) (*4*). Most of the agencies in the United States were developed after 1945. The impetus in the postwar years may be attributed to the dislocation in patterns of family life caused by new centers of employment, and to new theories of child care resulting from the war-time experience with children in institutions. Approximately one-half of the agencies surveyed in 1958 limited their services entirely to children.

This development was accompanied by the emergence of "homemaker" services as a specialized field of professional activity, and by a corresponding and continuing interest in the potential of these services on the part of the Federal government. (In 1937, the United States Children's Bureau sponsored a conference of agencies providing homemaker/housekeeper services, the result of which was the organization of a "Committee on Supervised Homemaker-Housekeeper Services." In 1946, this committee became the "National Committee on Homemaker Service" (*5*), which depended partly on the voluntary efforts of agency members and was assisted by agencies of the Federal government. A national organization—the National Council for Homemaker Services—with paid

staff, a Board of Directors and provision for membership was formed in 1962 "to stimulate the expansion and promote the improvement of homemaker services throughout the country." At approximately this same time, the title "homemaker" became "homemaker/home health aide" in order to describe more accurately the scope of services provided.

The major preoccupation in the field in these years centered upon a small but significant set of problems, some of which are as yet unresolved, and some of which have been clarified for providers and recipients of services but only partially for the public.

The first consideration concerned the *characteristics* of the "homemaker," who was no longer seen as a simple domestic but rather as an individual with specially selected personal characteristics. She was chosen because of her maturity, her interest in people, her flexibility, and her capacity for independent judgment. These were to be enhanced by training and professional supervision.

Such personal characteristics were important to the family service agencies, which were the primary settings for these programs up to the 1950's. Geared to child care and supervised by social workers, these agencies saw the homemaker as an important therapeutic agent in the maintenance of emotional security in children threatened by family crisis. Training programs were developed within these agencies—usually on the job—and focused on the individual needs of the families served by the agency.

The *setting* in which the homemaker functioned was a second consideration. The casual employment by private individuals, whatever the capability of that help might be, was not considered "homemaker" service. The concept was established that homemaker services must be provided by an organized community service, or by recognized public or private agencies professionally staffed and providing qualified supervision. Agencies were to be employers of homemakers, responsible for selection, training, and evaluation of the need for service, and for acceptable personnel practices, particularly for homemaker employees.

Emphasis on child care, as the *primary focus* of organized services continued into the 1950's, although definitions of the uses of homemaker services made passing reference to the appropriateness of the service for adults—particularly older persons with physical disabilities who might be able to remain in their own homes if supportive in-home services were provided. This growing awareness of the health needs of the older population began to affect the approach to homemaker services. *Chronic disease* in increasing numbers of older persons in our population stimulated the development of programs for *prevention and control.* Federal

programs of public assistance to needy "totally and permanently disabled" adults under 65 years of age, the enactment of Kerr-Mills legislation providing medical assistance to the aged, and finally, the passage of Titles XVIII and XIX of the Social Security Act (Medicare and Medicaid) stressed the public responsibility for the health of persons over 65 and for financially dependent persons of all ages. These factors stimulated both the extension of homemaker services to adults in many of the established programs and the development of new programs directed primarily to services for adults.

The Issue of Personal Care

With the development of services to adults, an issue of major importance to providers of services became apparent—the issue of *"personal care."* It was not an entirely new issue; there are repeated references in early committee and council meetings to the question of "auspices," which was related to the training and supervision of the paraprofessional who provided personal care. The "ideal" placement of community homemaker services—whether they were more appropriate in social or health agencies, in public or voluntary agencies, as an ancillary service to a general program or an "independent" or "free standing" community-wide service—became a matter of considerable discussion. Advocates of differing auspices appeared to believe that the essential *nature* of the services differed according to the auspices under which they were administered. Emphasis on a health care setting as a prerequisite for the delivery of personal care services was one aspect; the "social" nature of the services and their essential connection with social agency auspices was another. The limitation of services to the "poor" in public agency programs was one aspect of the public versus voluntary approach; the tendency to serve only the fee-paying population in voluntary agency auspices was another. The repeated observation that the soundness of the programs with respect to administration, professional competence, training, and scope of services was the overriding consideration, whatever the auspices, appeared to resolve this problem at least temporarily. The question of "personal care" was underlined by the subsequent legislative approach to the services.

"Personal care" in homemaker services is often referred to as the "laying on of hands." Quite simply, it involves essential services to a sick child or adult which are necessary in a supportive routine; it may go beyond this to limited therapeutic services. Assistance with bathing, dressing, getting in and out of bed, walking, toileting, and shampooing hair are activities which are considered a part of personal care. The care of the sick in their own

homes is not possible unless these services are available. Because they are related to health care and nursing services, and because such physical services may involve a degree of risk, the question of their inclusion as an accepted part of homemaker services was one which excited a good deal of attention.

This emphasis on personal care as a problem is primarily a result of developing adult services. Homemakers had, as a matter of course, provided personal care in child care programs both to children and to incapacitated parents of children: several of the homemaker manuals in the larger established agencies identified these activities as routine before 1959. A national survey of homemaker services in 1958 directed one of its sections of inquiry to the number of families with ill or disabled members receiving services. In a given week, 83 percent of all families receiving services had an ill member in the home, and 10 percent had an ill member in the hospital. It is safe to assume, therefore, that a proportion of these were receiving personal care services from the homemaker.

The "problem" at this time was probably underlined by the fact that many established programs existed under the auspices of social agencies, giving rise to the questions: Should personal care services be provided only under the auspices of a health agency? If so, how should social agencies deal with families in which the precipitating need for the service was illness? Many of the agencies considering these questions avoided the personal care responsibility by requiring the availability of a "responsible person" in the home to undertake personal care activities. In the instances where environmental services were reduced or eliminated, homemaker/home health aide programs which did not offer personal care limited the usefulness of their services and closed off an important resource for home care to those most in need.

The issue was not settled at the 1959 conference, but a specific recommendation with respect to personal care was made:

> "The National Health Council should call together a small committee including administrators of homemaker service programs and representatives of professional and practical nurse organizations, the American Medical Association, American Heart Association, American Cancer Society, National Foundation, American Public Health Association, etc., to draw up general guidelines and recommendations concerning permissible limits of personal care to be given by homemakers and suitable requirements for supervision."

This conference, which took place at Arden House in February of 1960, concluded that:

"Just as the 1959 National Conference on Homemaker Services recommended that homemaker service should be considered an integral part of medical care, so this conference recommended that personal care should be considered an integral part of homemaker services" (*6*).

A definition of personal care and guidelines for these activities were established at Arden House, emphasizing careful professional evaluation of need on a case by case basis, adequate supervision, and training appropriate to the level of need of the homemaker for knowledge and skill in the performance of personal care activities. This resolution of the personal care issue, combined with continued extension of adult services, stimulated the inclusion of content and practice in health care in training programs for homemaker/home health aides, and the development of stronger liaison between nursing services and homemaker services.

Between 1962 and 1967, a number of community projects were funded by the United States Public Health Service under the Community Health Services and Facilities Act (PL87–395) with emphasis upon demonstration of the effectiveness of homemaker/home health aide services in the health care field.

Reference to the term *"home health aide"* appeared in Federal legislation, first with respect to Medical Assistance to the Aged (Kerr-Mills), and subsequently in the Medicare and Medicaid titles of the Social Security Act (Titles XVIII and XIX). Provision for the funding of home health services in the health insurance program, including the services of a "home health aide" who would provide personal care and limited environmental support, distinguished the "homemaker"—who by definition already provided such services—from the "home health aide"—who might provide similar services under the auspices of a "home health" agency. This occurred at a time when a proliferation of similar titles for non-professional personnel, all performing similar functions, had begun to appear under the auspices of the poverty programs.

The recognition in Federal legislation of the importance of in-home services—and particularly of the role of the supervised, trained, non-professional worker in home health care—provided an important impetus. Homemaker/home health aide services were acknowledged as a necessary resource in the array of community health care services.

The Establishment of a Standards Code

In 1965, the Chronic Disease Division of the United States Public Health Service and the Public Welfare Administration pooled resources with the National Council for Homemaker Services to make possible a workshop which developed "Standards for Home-

maker-Home Health Aide Services" (*7*), the title establishing the concept of a set of inclusive functions undertaken by a *single* worker, namely the homemaker/home health aide. This document established a code of standards for the services, setting forth their purposes and functions, service methods, standards for organization, administration, staffing and training. The standards were supplemented in 1969 by an Addenda in which the intention as stated was to "supplement and amplify" the standards, and in which it "notes with emphasis that the homemaker and the home health aide are one and the same person" (*8*).

This statement had as its goal the elimination of duplication and fragmentation through the inclusion of the interrelated "homemaker-home/health aide" functions under a single title. With the growth of "home health" services in the Medicare program, and the inclusion of aides in home health agencies, national nursing organizations developed similar guidelines and standards for their services.

The Pittsburgh Conference: Enunciation of Principles

In March, 1968, because "the Health Insurance Program for the Aged has given rise to problems and issues relating to the use of the (homemaker/home health aide) service, its supervision and direction and its organization in the community," the Division of Medical Care Administration of the United States Public Health Service sponsored a two-day workshop "to clarify and resolve some of these issues as a basis for the further development and extension of homemaker/home health aide services" (*9*). Providers of service, as well as representatives of organizations concerned with their use and development, were invited.

Workshop participants recommended that present definitions of the National Council for Homemaker/Home Health Aide Service, the National League for Nursing, and the American Nurses Association be reviewed. The health related potential of the service was emphasized in the preamble to the report of the conference:

> ". . . during the past ten years we have seen a new type of supportive health manpower emerge capable of helping professional staff to meet the health and social needs of ill and disabled persons and their families" (*10*).

The principles enunciated as a result of this workshop provide an approach to homemaker/home health aide services which is basic to quality:

> In principle, the services of the homemaker/home health aide are a part of an array of services for care of patients in the home and their use is based on an on-going assessment of

the patient's total health and social needs within the context of the family and the plan of care;

In principle, patients and families should have a service which meets both social and health needs implying that the activities of homemaker/home health aides should be delegated to one person who works under professional supervision;

In principle, training of the homemaker/home health aide should include preparation for assuming the duties of both homemaking and personal care in order to meet the health and social needs of patients and families. It follows that to carry out such training the faculty should include a variety of professional disciplines;

In principle, professional supervision is basic to the delivery of homemaker/home health aide service;

In principle, a community should have available homemaker/home health aide services to meet the needs of individuals in all age groups and socio-economic sectors (*11*).

THE PROBLEM OF FINANCING

Definition of the services, the establishment of a code of standards, and the enunciation of principles in order to open the way to development of quality services which are inclusive in scope were not the only areas of concern. An important issue—and one which controls the growth of viable services and their establishment as a reliable resource—is the issue of financing. There has probably never been a meeting of any group of administrators of homemaker/home home health aide services in the United States, of any community group interested in developing services, or of any professionals interested in devoting their competence to such services in which the problem of funding has not been paramount.

The early programs looked to "the community" for funds. The "community" meant charitable organizations such as the United Way, gifts from individuals and foundations and, when possible, fees for service from recipients. By 1950, these sources were supporting 65 homemaker agencies in the United States—all of them in voluntary social agencies (*12*).

The Beginning of Federal Funding

The results of the 1958 survey indicated the sources of Federal participation in financing homemaker/home health aide services: approximately one-fourth of the cost of the services in the United States in 1957 came from Public Welfare funds. Of this amount,

about one-third came from child welfare programs which allowed states to include homemaker services in their plans. Almost two-thirds came from Public Assistance programs which provided 50–50 state-Federal matching of administrative costs for public welfare programs administering their own homemaker services. Purchase of service from voluntary sources was not possible; (this prohibition against direct purchase of service from homemaker agencies by public assistance programs was removed in 1967 amendments to the Social Security Act).

A small percentage (about 10 percent) was made available for payments to families to enable them to purchase services (*13*). Agencies reported that these payments to families did not invariably reach the service program; collection from families living at the marginal level was a recurring problem. The remainder of the approximately $4-million expended in the 143 agencies providing homemaker/home health aide services (90 percent of them under voluntary auspices) was produced by an unremitting investment of effort in fund raising on the part of the agencies themselves—an investment which siphoned off most of the energies needed to develop and expand quality services.

The situation was improved somewhat with Medical Assistance to the Aged (1960). An increase in Federal-state matching to 75 percent–25 percent for administration of homemaker services in public assistance (1962), and the enactment of Titles XVIII and XIX of the Health Insurance Act, brought additional Federal funding into the field. As a result, during the period 1957–1966 there was significant growth in the development of new programs. There were approximately 600 programs: one-half limiting their services to children, and approximately one-half under public auspices.

Services provided specifically under health auspices to meet the "home health" requirements of the health insurance program was an aspect of this growth. One-third of approximately 1,700 participating "home health" agencies offered "home health aide" services as of March 1967—one year after enactment of the legislation (*14*).

Homemaker/Home Health Aide Services and Medicare

Public funds available for the provision of services to adults—particularly in the over 65 age group—created a caseload with multiple problems primarily related to the needs of sick older persons. In the *Conditions of Participation* of Medicare, emphasis was placed on personal care. Limited services were provided for environmental maintenance. The requirement that recipients of the services must be severely restricted in physical function yet

not "custodial," and the requirement that patients must be in need only of "part-time, intermittent" services presented communities and agencies with the problem of developing supplemental sources of funding for patients who frequently need homemaker/home health aide services but are excluded by these limitations.

It has been pointed out that homemaker/home health aide programs find it difficult to adapt the acute care concepts implied in the Medicare program to a caseload which is beset by problems of chronic disease (*16*). A genuine effort to meet real need is now an established principle of the services. Differences in perceptions of "chronic disease," of service according to need, and of service by regulation have been accurately described in relation to this problem:

> "The terms 'acute illness' and 'chronic illness' are used ambiguously by health care workers. Neither term refers to the *severity* or *degree* of illness but only to its probable duration. A person can be very sick for a short or long time, or mildly sick for a short or long time. From any degree of illness he can get better or worse. There seems little *medical* reason for segregating the chronically ill from other sick people" (*17*).

If the problems of funding have not yet been solved, Federal legislation should have significant salutary side effects on homemaker/home health aide services. The importance of the regulatory approach tying financial participation to requirements for quality could in time improve and strengthen homemaker/home health aide services. The enunciation of principles in the regulations involving sound administrative decisions concerning appropriate use, the development of effective treatment plans, supervision, and the interrelationship of health and socio-economic problems, might affect all homemaker/home health aide services.

The positive effect of the legislation is only realized, however, when regulatory principles which support quality are applied in a manner which stimulates utilization and which recognizes flexibility and professional judgment as the basic elements upon which such quality services must rest and from which extension, expansion and creative approaches may be developed.

Funding necessarily affects program growth. It is improbable that growth can occur without the development and support of a national policy, expressed in legislation and implemented with appropriate funds.

Established programs have attempted to develop training programs appropriate to service needs over the years. Requirements in the Federal regulations concerning the training of homemaker/home health aides who are employed in home health agencies have had some effect in stimulating training programs. The training of homemaker/home health aides has become an important concern in a variety of national organizations (i.e., the National League for Nursing, the American Nursing Association, and the National Council for Homemaker Services). Many of them produced recommendations and/or guidelines for the training of homemaker/home health aides. The "approval" process established by the National Council for Homemaker/Home Health Aide Services in 1971—which projects a system of agency accreditation—requires adequate training of homemaker/home health aides.

The Potential of Homemaker/Home Health Aide Services

In the United States, there now exists a context in which homemaker/home health aide services may function; a set of goals; standards for the organization and administration of sound programs; the concept of professional interdisciplinary competence; and recognition of the valid results which can be achieved in the training of paraprofessionals. Acceptance accompanied by the same financial support accorded other essential institutions is necessary in order to add an important component to the array of resources necessary to our community life. Such services are not "extensions" of our established institutions; they add another element to comprehensive community services—an approach which avoids the dislocation of the institutional experience, denies the inevitability of the institutional end-of-the-road dumping ground, and supports the quality of life within the community.

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CHAPTER 2

Home Help Abroad

European programs providing "home help"—homemaker/home health aide services—differ from country to country with respect to auspices, training, patterns of service and emphasis on selected population groups. They are alike in one respect: the keen interest which is expressed by government in the development, maintenance and expansion of the services.

This interest may be attributed to a variety of causes. Home help programs in Europe have a longer history than those in the United States. The first program in Europe to provide services in the home was organized in Frankfurt in 1892, and was followed by a similar program in London in 1897. These services developed under voluntary auspices—usually religious—and over a period of time demonstrated their potential value. European interest in the family and the preservation of family life is deeply embedded in cultural attitudes; and this interest is expressed in many aspects of social planning. In general, there is less interest in institutional solutions to problems of illness and family crisis, due largely to this family-centered culture, and probably, incidentally, to economic considerations—the financial aspect does not appear to be a primary consideration.

The effects of two wars on the populations of European countries has also been a major influence, especially in terms of their effect on children. Particularly on the continent, a strong philosophy with respect to sound child rearing practices resulted, and stimulated interest in direct approaches: the entry into the family unit of trained personnel to support healthy patterns of child care.

In addition, many of the changes in living patterns that confront us here are also occurring abroad—increased mobility threatens family unity and the extended family is less available in periods of crisis. Concurrently, there has been the rapid growth of an aging population—and with it the problems of chronic disease and the multiple needs of the aged for environmental and socio-economic support. "The home as the sociologist understands it, has broken down under the pressure of industrial development, and two wars have doubled this pressure. We might therefore say that the home has perished and the Home Help Service has begun" (*1*).

From World War II on, European governments have been involved in home help services in various ways: through legislation; through regulation and standardization of supervision, training and practice; through administration; and through direct financing or subsidy. This active participation has affected program growth; but more significantly, it has affected the status of home help services. Home help programs are considered essential. Workers who are employed in the programs are respected and the conditions of their employment are protected. The field is generally regarded as one which is vocationally interesting and worth entering.

The results of long experience and practical government support can be seen first of all, and most impressively, in service volume. Swedish programs, which in 1943 employed 200 home helps, employed 4,000 in 1968: a ratio of one to approximately 2,000 population (a ratio of one to 1,500 population has been estimated as an adequate standard). In 1968, Denmark had a ratio of one home help to 760 population (6,200 workers); Norway, one to 1,000; and Belgium, one to 2,700 (*2*). Programs in Great Britain employed 3,000 full-time and 32,000 part-time home helps in 1955 (*3*). By 1969, 69,000 home helps were employed (*4*), with the ratio of part-time to full-time workers remaining approximately the same. However, part-time workers spend about two-thirds of their time in full-time employment.

The Netherlands—which counts both workers who have had full formal training and those who have not (namely, untrained and partially-trained home helps of which there were 30,289 as of January, 1970), as well as those who are employed full-time and those who work part-time—has approximately 35,712 home helps (about one-half in each of the above categories) serving a population of some 13 million (*5*).*

In France, (which had set a goal of 13,000 trained home helps by 1970) there were about 5,000 in 1968, a ratio of approximately one to 10,000 population. Their current total estimated need is approximately 22,000 workers: one to 2,500 population. The disappointing growth in the French programs was sufficiently important to occasion debate in the French National Assembly (*6*). Germany has approximately one trained worker to 5,800 population (about 3,000 workers) (*7*). Switzerland has one worker to 2,900 population. In most of the programs a need is expressed for addi-

* Dr. J. M. B. Scholten of The Netherlands emphasizes the overriding concern in home help programs with the provision of those services which will maintain or re-establish healthy patterns of family life in the home. Prior to 1920, such programs tended to provide services only to the sick. Expansion of services to support family life whenever it was threatened occurred in the period 1920–1949.

tional workers in order to achieve a better worker-to-population ratio.

European Attitude Toward Home Help

The general attitude toward services in the home prevalent throughout Western Europe is best expressed by the following remarks made by a leader in a remarkably innovative home help program in Sweden:

> "In my country we now find it natural for various reasons —humanitarian, labor-economic, and socio-economic—that nobody should stay in an institution if his social or medical problems can be solved in other ways.
>
> "No old person should live in an old age home just because he has nowhere else to live, lacks furniture, or cannot clothe, clean or cook for himself. Lodgings can be provided, furniture can be bought, and home help can be found. Thus the individual's independence, a very precious thing in human existence, is saved—and always at a lower price than institutional care.
>
> "No one acutely or chronically ill should have to stay in a hospital if ambulant medical treatment or day hospital care could be used, maybe in combination with home help.
>
> "No child should be separated from his home and taken to a children's home because of the mother's illness or death. . . .
>
> "The wife of an alcoholic or criminal . . . can, of course, consult the doctor, the social worker, or the priest, but often the home help is her proper aide. . . .
>
> "The experienced home help can encourage and stimulate the handicapped housewife. . . .
>
> "The mother with too many children who, because of failing health, has not strength enough to manage . . . needs some kind of home help to save her from overstrain.
>
> "A single father or mother who has a full-time job outside the home can somehow manage to do the household work in his or her 'spare' time. A capable home help who comes in regularly . . . may prevent exhaustion and raise the standard of the family" (*8*).

CHARACTERISTICS OF HOME HELP WORKERS

Most European programs have well developed and clearly formulated ideas about the characteristics necessary for workers in home help services. The very wide variety of activities assigned to home helps, the length and content of most training programs,

and the complexity of problems found in families considered candidates for home care indicate that home helps are expected to assume a good deal of responsibility.

> "Making the best use of home help . . . depends, among other things, on the sort of people we can recruit, the quality of the training, how much we are prepared to pay, and the competence of the direction" (*9*).

In legislation, regulation, and prerequisites for entry into training, the personal and physical requirements which are essential are stressed. The following is the description which appears repeatedly in publications which describe the qualifications of the French "Travailleuse Familiale."

> "The profession . . . is an exacting one which demands indispensable aptitudes and qualities . . .
>
> *Physical:* Good health, stability, normal vision and hearing, manual dexterity, quick response.
>
> *Intellectual:* Capacity for observation; sustained interest; systematic approach; a sense of organization; a good memory; discrimination, good sense, judgment.
>
> *Personal:* An exceptional capacity for adaptation to people and to situations; flexibility and understanding; a social sense which is "open" to others; a sense of responsibility, emotional maturity; composure, self control; an affection for children; respect for household work (*10*).
>
> An *indispensable requirement* is the capacity to be discreet ("confidentiality") (*11*).

In Denmark, the Ministry of Social Affairs states:

> "Considering that . . . (it) is a very exacting task and that very much depends upon the manner in which it is carried out . . . her general ways and personal conduct are of very great importance . . . a thoughtless word or a rash act may very well harm the patient, the home, herself, and the institution for which she works.
>
> ". . . (*she*) *should be kind and helpful* in all circumstances and should always keep in mind that the sick and the elderly are often in difficult situations" (*12*).

In The Netherlands, a report on training home helps points out:

> "She must be able to work in all sorts of environments and under widely divergent circumstances . . . bearing responsibility . . . especially (for) children and old people . . . maintaining or creating a good atmosphere in the home . . . She must be able to accept the guidance of the supervisor. . ." (*13*).

The Belgian statutes state:

> "The family aide has respect for the individual, for the liberty of conscience, and for the opinions of everyone . . .
>
> "All that she learns, everything that is confided to her as she goes about her work must be a professional secret . . . even after her contract is terminated . . . She must respect and enrich the human dignity of her work" (*14*).

Emphasis upon the need for flexibility and understanding and for a temperament which has the special qualities of tolerance, kindliness, stability, and respect for privacy, is universal. Requirements which stress with such specificity "the sort of person" required, in terms of temperament, attitude and physical characteristics, are directly related to the concept of the importance and usefulness of the services.

Maturity and Age

Programs in the United States usually stress "maturity"; and there has been a tendency here to see this in chronological terms. Although maturity is implied in the European definitions, the "mature" home help is usually expected to achieve this quality through a combination of inherent characteristics, good training and supervision—it is not, in general, related to age. There is, in fact, considerable variation with respect to age requirements in the European programs, with a majority tending toward a younger age range. This is probably related to the prevalent attitude toward home help work as a vocation or profession—one which is selected in time for the necessary preparation to be completed early in life.

Some European programs set the age range in government regulation. Sweden accepts for training young women between the ages of 20 and 30; younger recruits are accepted for employment in certain aspects of in-home care in several of the programs: in Belgium the "senior helper" must be 25 years of age to qualify for admission to training and the "homekeeper" must be 17 years of age (there is a difference in length of training and work assignments in the two age groups). Holland accepts recruits at 18, but makes a distinction in both training and work assignments between the "Homemaker" (fully trained) and the "Home Help," who may be very young (15–16 years of age) and receive less training and very limited assignments. The minimum age for Denmark is 25. West Germany accepts recruits for training between 18 and 35 years of age. Older recruits are considered if they have had experience in the field (in institutions or hospitals), and are willing to complete a specially designed program.

Switzerland accepts trainees in two age ranges: girls between 18 and 25 are required to complete a training program which is six months longer than mature recruits (accepted in the age range 25–40). France requires a minimum age of 20.

All of the programs show in their publicity, and describe in general, a group of attractive, youthful workers: robust, and cheerfully performing a wide variety of household and personal care tasks. England emphasizes the chronologically mature home help. The English program—which had its major development during World War II, when younger workers were employed in war industries—drew primarily upon housewives. They were considered to be already experienced in homemaking, capable of providing services to children and, most important, the aging population and the disabled who, because of the war, no longer had family members available to them and for whom institutions were virtually non-existent. Women whose children were in school or employed and who were available for work on a part-time basis were a major resource. The pattern of recruiting mature experienced housewives able to work during those hours when their own household responsibilities are minimal has continued.

None of the European programs appears to support an idea occasionally advanced in the United States: that the work of the homemaker/home health aide is an excellent employment resource for the "older" worker, *who cannot, for reasons of age,* take on more rigorous employment.* Maturity is seen as a temperamental characteristic. It is quite evident from the range of services provided and the general content of training that the field is one in which the entry requirement of good health appears to be amply justified.

THE QUALITY OF THE TRAINING

European programs in general place a great deal of emphasis on training. The longest training period is required in West Germany,† which provides two years of training—one year in a

* In commenting on this statement, Dr. Scholten of The Netherlands points out that England has had excellent experience with women in the age range 40–55 "who have brought up a family" and are experienced; that other countries, particularly Japan, use older workers. The author's emphasis is intended to counteract the impression that the work is a "last gasp" resource for older persons who may not be suited to the work at all.

† Dr. Scholten also points out that variation in length and content of training is related to the program's objectives; those which require considerable specialized knowledge and relatively more complicated tasks (particularly in the health field) are required to complete longer periods of training and a more technical curriculum. He also comments that numbers of personnel and

residential school and one year in supervised institutional assignments (hospitals, homes for the aged, children's institutions) and in the field. Switzerland and Holland require 18 months of training (Holland currently plans to increase the requirement to two years); Finland requires approximately 20 months; Sweden, 15 months; and France, seven months. Belgium has differing requirements in training for its two categories of workers: the "home helper" who is "polyvalent" (i.e., capable of serving in all situations) is required to complete 450 hours of theory, 15 days of institutional field experience and from 500 to 1,500 hours of supervised on-the-job training. The "senior helper" must complete 200 hours of theory, 150 hours in an institution for the aged (senior helpers are assigned exclusively to the aged), and a period of 150 to 300 hours in "practical training" with the aged and sick. Denmark offers a training program of two months following a period of six months of on-the-job experience. Supplementary "short term" courses are organized. England provides two to three weeks of training, plus short-term institutes and on-the-job training.

Residential versus Day School Training

There is considerable variation in the attitude toward residential versus day school training. Germany, Switzerland, France ** and Sweden provide a major part of the training in residential schools.

> "A good pedagogical environment is needed for the assimilation of the material. A residential school offers most favorable opportunities . . . (it) enables trainees to take an objective view of their own background . . . and . . . to know other ways of life. . . . More intense contact provides opportunity . . . to . . . the staff whose chances of observation are improved so that the trainees' capacities can be assessed more completely. The residential school must not be . . . only a boarding institution, but a 'forming center.' The building must provide space in which to stimulate learning while permanent group leaders must . . . guide the group throughout the entire course" (*15*).
>
> "Seven of the nine schools in Switzerland are boarding schools . . . As director of a *day school* I cannot but say what excellent results I have had during the last 17 years

length of training are related to the legal requirements of the country—as of the date of his comments (March, 1971), six of the Western European countries have legal requirements related to training.

** The training school in Paris is a day school; and the period of study extends beyond the seven month requirement to approximately one year (including field experience).

in our day school. . . . I am sure the majority of my colleagues prefer boarding schools . . . and I respect their opinions. Regarding the way of life of the younger generation, the day school may perhaps have the right on its side" (*16*).

Recruitment problems, which are beginning to develop, and the possibility that the mature worker may become a necessary and valuable recruitment source have raised some question about the commitment to boarding schools for training. Those who are committed appear to be reluctant to relinquish this pattern of training.

The writer discussed at some length the varying attitudes toward extended training programs with several of the leaders in the European home help field (*17*). The rationale appears to be based upon several considerations. These, of course, differ according to the circumstances within the country involved, and the extent and scope of the services required of the home help within the different programs.

1 It is generally accepted in all programs that entry into the home, whether the services offered are extensive or limited, is in itself an activity which requires an unusual combination of qualities: sensitivity, judgement, and discrimination. There must also be a well developed capacity to adapt with tolerance to a wide variety of situations in which service recipients, who are usually in crisis, make heavy demands upon the home help who provides the services. Most program leaders stressed their conviction that these attributes are reliably produced by careful and extensive training.
2 There is considerable difference among countries in the basic education which has been available to trainees prior to entry into the field. "Many of the girls are postwar children. They have had little schooling, they have never known family life; if they are to help others they must be carefully trained" (*18*).
3 In several of the countries, a primary recruitment source has been rural girls. ". . . in Switzerland, the home helps are recruited nearly exclusively from country people. For instance, since the foundation . . . of the school of Zurich, 95 percent of the registrants have been the daughters of farmers. . . . We try in our schools to show the problems of the city and the country and to point out which are common to both and which are different" (*19*). The Scandinavian countries are among those whose trainees are drawn primarily from rural areas.
4 Countries which stress younger trainees see the necessity for extensive training as essential vocational preparation.

5 The range of services offered in the various programs appear to affect the length of training. The definition of "personal care" as it has been established in the United States, is much extended in many European programs to include services of considerable complexity for which longer training is considered essential.

Program Content

Training content in the various programs is related to these factors. It is similar in almost all programs that offer organized training, differing only in emphasis. Those programs which to some extent intend to replace basic education (what we have recently begun to describe as "remediation") provide in their training programs for education in language (written and oral), mathematics, bookkeeping, money management, literature, music, athletics and gymnastics (apparently different activities). This general instruction is not extensive: at most it takes up 96 hours of a 2,070 hour curriculum in Germany, and the same number of hours in a slightly smaller total in Switzerland. It is not included in the Belgian, Danish or French courses—possibly because basic education is presumed to be adequate.

In France, for example, selection of recruits is preceded by entry examination:

> "To make good use of [the course of study] the home help must be able to reflect, compare, investigate, judge. She must be able to take notes and to comprehend the thought of the person who gives the course.
>
> "This is determined by an entry examination: in spelling, language formation, good sense; a psychological examination to determine aptitude; a trial period to determine qualities related to judgement, capacity to organize ideas and to take notes" (*20*).

The course of study in organized training programs is divided into training in theory, in practice, and in special fields of practice: i.e., field instruction and practice in specialized institutions (*21*):

A. *Theory*

Theoretical training begins in almost all programs with a discussion of the service.

I. The service

Range in emphasis: 90 hours to 7 hours	
	The profession
	Professional and ethical practices
	Behavior patterns and patterns of life (life styles *)

* Author's parenthesis

Customs of the country
Moral problems *
Religion **
Social structure; its significance for beneficiaries (Belgium)

II. Professional *** education

1. Housekeeping

Range in emphasis: 416 hours to 46 hours

Household management
Demonstration
Nutrition instruction and diet
Cooking, baking, sewing
Care of laundry
Housework
Horticulture/care of flowers (Switzerland)
Purchase of food and supplies
Budgeting
Gardening and care of cattle (Finland)

Almost all programs emphasize the *teaching* of nutrition and good diet as a responsibility of the home help.

2. Nursing

Range in emphasis: 360 hours to 32 hours

Principles of good health and maintenance of good health
Personal hygiene
Teaching the care of the sick
Care of the sick
Infant and maternity care
Pathology
Pedicure (Denmark)
First aid

III. Raising children **** (Family life)

Range in emphasis: 246 hours to 6 hours

Cultivation of family life
Child development and training
Teaching child care and development (applied pedagogy)

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* In the sense of tolerance, adaptability, restraint in making personal judgments, respect for family integrity; not in our literal interpretation of the word.

** Germany, Switzerland, Holland, Belgium. Holland: "Religious training and/or basic attitudes to life. Orientation with respect to currents in religious thought."

*** The word "professional" which is used consistently is usually meant in the sense of following a chosen occupation. In France, however, it is used in the accepted sense: the French program emphasizes that it considers the Travailleuse Familiale a professional worker.

**** This is not so specifically related to child care as it is to family life—it includes care of the aging and "training for aging" (France).

Teaching occupations for children (vocational guidance)
Family problems
Problems of the aging
Care of the aging
Handiwork and hobbies (Finland)

Here again, teaching ("pedagogy" is one of the subjects taught in almost all programs) is the responsibility of the home help.

IV. Knowledge of Social Work *

Range in emphasis: 170 hours to 13 hours

Social science including family affairs
Social science; manners and customs; family life; welfare and professional practices; law, social legislation, citizenship, cooperation between home care and other social services.

B. *"Procedures"* (Practice).

Range in emphasis: 510 hours to 80 hours (1.) 274 hours to 50 hours (2.) 768 hours to 85 hours (3.)

1. Care of the sick and aging.
   Given in hospital, nursing home, outpatient department, homes for the aging and chronically ill; in the home.
2. Prenatal and infant care.
   Given in foundling home, maternity home, in family placement.
3. "Raising Children"
   Children's home; day care center; kindergarten; in family placement.

C. *Professional Procedures* under direction and supervision of school (In-service training).

Range: 12 months to two weeks.

Most of the schools are government financed, and tuition and maintenance are provided the trainee, either by the government or by a combined funding (private program or local authority plus government subsidy).

Various countries emphasize different aspects of training, according to program need. There is relatively greater emphasis (in hours related to the course total) on household services in Sweden and France; Germany and Finland devote relatively larger sections of training to care of the sick; Switzerland and France emphasize larger blocks of time in institutional practice; and Germany and Holland require one full year of extended

* "Social Work" in this context is related to social insurance and the rights of the family and the individual in the social system—very important in European countries, as well as to social work concepts as we know them.

(supervised practice) training under the direction of the school (*21*).

The course of study in Great Britain, which relies primarily on on-the-job training, covers much of the same material as that which has been outlined above: household management, nutrition and special diets, and personal care (lifting, turning the patient in bed, hygiene, and first aid) (*22*).

Training is usually provided by qualified professional instructors drawn from the specialized fields:

> "Training centers must submit for approval a detailed program of subjects taught . . . (they) must be taught by professors qualified in the subjects as follows:
>
> Doctor of Law
> Diploma of Administrative Science
> Diploma of Political and Social Science
> Diploma in Social Work
> Diploma in Psychiatric Medicine
> Diploma in Psychology
> Diploma in Pedagogic Science
> Diploma of Doctor of Medicine, Surgery, Obstetrics
> Diploma in Nursing
> Diploma in Home Economics
> Diploma in Agricultural Management
> Professional diploma in other subjects according to the specialty taught.
>
> Authorization to teach certain courses may be given to other persons who are particularly qualified in family problems or specialists in group dynamics" (*23*).

There is apparently a strong coordinated system which integrates the central training facility, the institutional field practice, and supervised training in family placement, particularly in those countries which have extended and well developed training programs.

THE SERVICES: SCOPE, DURATION, LIMITATIONS

In all of the European programs heavy emphasis is placed upon those services which protect and increase the quality of family life and which "instruct" families in methods intended to achieve these objectives. This by no means implies that the assignment of the home help is confined to teaching.

Housework

Home helps in all European programs are expected to perform those household tasks which are a part of the normal homemaker's routine. In England:

"We expect home helps to do *whatever is needed.* They are sent in to help. This means unlimited service except for those tasks which cannot be safely undertaken. It is far better to give unlimited service . . . at home (including medical care and supportive services), than to put them in hospital or nursing homes" (*24*).

The care of incontinent bedfast patients is considered a normal part of the home help's assignment in England. The English program supplies a "Blitzclean" service for heavy janitorial work; meals-on-wheels programs have been developed; and home help services are coordinated with the services of the district nurse, the physician, the geriatrics worker, and the Mental Health officer.

In France:

"All of the tasks habitually undertaken by the homemaker: housework, cooking, the care of children, laundry, ironing and mending (laundry of drapes, washing of large windows are forbidden; laundry of household linens is limited to two hours a day)" (*25*).

In Sweden:

"The trained home help . . . is expected to work in homes of the most varying standards and economic resources and to take over all the regular household duties such as cooking, shopping, cleaning, taking care of the children . . . helping them with their homework and also, at times, doing some nursing. Although a home help is expected to do the housewife's ordinary work, we should expect a competence far beyond that of the *ordinary housewife.* . . . (Emphasis added)

"The permanent home help to the chronically ill or handicapped . . . or old people who are more or less ill who, besides the ordinary housework must be prepared to help with personal hygiene and do some nursing . . .

"The home help to old people living in sparsely populated regions where modern equipment is rare—people who can take care of themselves but need help to draw water, fetch wood, and shovel away snow" (*26*).

Food

Food preparation and nutrition are heavily emphasized in all of the programs. Home helps are expected to prepare substantial meals, to bake, to preserve and can (particularly in rural areas), and to be very knowledgeable about good principles of nutrition, particularly in child care and in the care of the sick. Convenience foods, supermarkets and specialized household equipment which

allow for food storage are only beginning to appear in many European countries; and the attitude toward mealtime as an important part of family life is still that of a more leisurely family-centered culture. The two-hour lunch period in which workers go home to lunch is still fairly prevalent; home helps are expected to continue existing family patterns and, where it appears to be deficient, to improve general family nutrition. English home helps may leave and return to a given home several times during the day, to provide for tea times as well as basic meals.

Care of Clothing

Mending, alteration of clothing, and the making of clothing—particularly in child care—are also provided in most programs. Here, too, the fact that the use of ready-to-wear clothing is not yet a basic way of life has its effect.

Personal Care

The word "nursing" appears frequently in training outlines and in brochures which describe European home help programs. Yet in interviews with this writer, program directors, in response to the direct question "Do you provide nursing care?" invariably responded negatively, saying that nursing services are provided by the district nurse. It appears that nursing services are somewhat more narrowly and specifically defined and "nursing care" more broadly viewed than they are here. Home nursing—which might normally be undertaken by family members—is naturally considered appropriate for home helps, but the services do seem to go beyond these. Many of the services related to prenatal care, postnatal care and care of the newborn—which we usually assign to the public health nurse—are in some programs (particularly those with extended training programs) provided by the home help.

In adult care, there is some variation between programs. English home helps turn the patient in bed and lift and move patients from bed to chair, but do not give bed baths. The longer training programs are geared to the provision of most services short of giving injections or doing very specific nursing procedures:

> "Whether those who need our services are old or young the primary presenting problem is illness. We surveyed for years and couldn't honestly say it has nothing to do with illness. Long training would not be so essential if nursing care was not such a big component in the services" (*27*).
>
> "In Switzerland, for instance, we agreed . . . to teach only nursing at home . . . Taking into account, however,

the general lack of nursing personnel in hospitals and old people's homes and of district nurses—a lack that makes necessary the early release from hospitals of patients into care of the Home Help Service— . . . we are more and more doubtful whether this agreement is still adequate. We ask ourselves whether it allows us still to give our future home helps the equipment they really need in nursing their ill clients" (*28*).

Most of the services which we consider "personal care" are provided; medication is offered in some programs. The training outlines indicate that "nursing care" of the aged accounts for from 33 percent to 40 percent of training time in four countries (Germany, Finland, Switzerland, Sweden), all of them providing extensive training. What is taught might come fairly close to preparation for the services given (with some restrictions) by a "licensed practical nurse" in the United States. "Pre- and post-natal care, baby-nursing, nursing of children" uses from 25 percent to 62 percent of training time in five countries (France, Switzerland, Finland, Sweden, Germany). What is taught appears to equip the home helps in these countries to provide a combination of the services that the United States public health nurses provide and/or teach family members to provide. England, Denmark and Holland appear to provide services that more closely parallel our definition of "personal care"; although English home helps do "give some medication." In all of the countries, however, provision of these services is firmly tied to supervision by the physician and the district nurse. The Scandinavian countries, primarily, add to the training and the services offered those which are more closely related to physiotherapy: positioning, body movement, prenatal exercises.

Social Services

Regardless of auspices and of the factor of illness as a presenting need, all programs are firmly committed to the overriding "social" and psychological considerations in both training and service. Supervision is most frequently provided by social workers. More important, there is a constant reiteration of the need for considerable knowledge of and sensitivity to psycho-social aspects in all situations.

> "Formerly in our society, the nuclear family . . . was held in by a larger network made up of relatives connected by blood or alliance . . . which constituted a sort of directing, enveloping protection interposed between the nuclear family and the diverse elements of the global society. . . .

"In the European culture there are innumerable situations which witness to the influence which family members attached to a name, to (family) goods, to family power; jealously defending their identity, watching over their traditions, strictly controlling their marriages and their lives, assuring their future. . . . In the societies of the old order there were innumerable lineages in which the paternal line and the maternal line were characterized by their strong solidarity, the existence of reciprocal rights and duties . . .

". . . (the) fabric of this network (of the extended family) has become attenuated, is unravelling, has been disappearing . . . and in the latter stages of this process the ties to immediate antecedents are in turn becoming more frail and more rare . . .

"Thus the family finds itself in direct confrontation with a whole range of relationships, contacts, institutions and organizations which make up the global society" (*29*).

This statement and the development of this analysis made in a keynote speech to the International Congress of Home Helps in 1969 explains to a very large extent the focus and intent of much of the extended training which is provided in many of the continental programs. The "normal" needs for assistance, which involve recurring practical problems—assistance when there is illness, when the mother of a family is absent, or when housing or other basic necessities are deficient—are taken for granted as an ongoing responsibility of the home help services. In addition, the family must have recourse to help which motivates, stimulates, reassures, and assists in those choices which make maximum use of social institutions, at the same time preserving that which supports internal autonomy:

"In their mode of action, and their approach the home helps must be particularly attentive to that reality which is specific to the family" (*30*).

"The home help can act as the intermediary between the family and the changing modern world" (*31*).

This "mission," or assignment to the home help of the responsibility to support the family "vis-à-vis an external world which is largely indifferent, a society which is neutral" (*32*), organizations and institutions which are complex and specialized, and choices which involve the clarification of the family's value system as against a confusing variety of choices and values, is a common characteristic in training content and the description of services.

"Deontology" and "Puericulture"—an important part of extended training programs—describe ethical training which goes beyond professional ethics to attention to family life that is in-

depth and specific. It is strongly family-centered and is most characteristic of continental programs, particularly those which place their major emphasis on child care—on the "family of the future." It also explains the distinction made between training for the care of the aged, the disabled, and the chronically ill which—in spite of the heavy component of personal care needs—is a shorter course, and in some countries makes use of a different kind of trainee (although the general trend toward the "polyvalent" home help has become evident). This approach does not exclude concepts which we in the United States include in psychosocial orientation of homemaker/home health aides and in the social services which are offered in our programs of quality.

There is great emphasis on family and individual autonomy, and on the enabling aspects of healthy relationships. Psychological concepts are very important in some training programs; and whether or not they are specifically taught, the very delicate position of the home help—intimately involved in the lives and problems of families—is thoroughly understood, and the value of objectivity combined with warmth is certainly recognized.

> "We do not have the right to go into a family and say 'You are not raising your children properly.' Or, 'You cannot do the work,' or 'You must do this or that.' This is one of the reasons we believe so much in adequate training programs. Inexperienced girls do not learn about such things without careful social training" (*33*).

A third aspect of social services, and one which is important in European programs, is related to the multiple "rights" of individuals and families to various benefits under the social insurance programs. Health insurance benefits, disability benefits, family allowance grants, supplementary grants to families with single earners, unemployment insurance, and pension plans play a very important part in the economic life of the European family, as do the many forms of private agency and religious group assistance programs. The home help, under professional supervision, is expected to be familiar with these and to assist families who are unaware of what might be available to them to take advantage of them.

In terms of breadth and scope of services, the program most admired in Europe—particularly in its services to the aged and chronically ill—is the program developed in Sweden. Virtually every need essential to safe and comfortable home care has been made mobile and is brought into the home.* Meals-on-wheels,

* Dr. Scholten supplements this with the remark that other Western European programs provide mobile services also—usually through arrangements with other public and/or private organizations.

physical and occupational therapy, mobile coiffeur and shampooing service, chiropody, transportation services, organized recreation and friendly visitors, and special restaurant services are important complements to the home help service and may even, in certain situations, replace it (*34*). Day care, and weekend and holiday homes are also a part of the Swedish program.

> "We are," a delegate to the 1969 International Congress of Family Service Associations stated, "strongly opposed to institutional care" (*35*).

Duration and Pattern of Service

Programs which emphasize child care, and in which care for the aged, disabled or chronically ill has either been a later development or is just beginning to develop tend to limit the duration of service. These distinguish between situations of crisis when one or both parents are temporarily ill and/or out of the home, and those situations where problems are of long duration and require a restructuring of family life with the assistance of the supervised home help. Germany limits the service to four to six weeks, with extension in very rare exceptions: Holland does not give unlimited (in duration) home help, but will provide extended care on the basis of the family situation. Belgium limits assistance in child care to two to approximately three months; Denmark provides child care assistance for 14 days with extensions *as needed;* France, which emphasizes care in situations where large families or unusual stress may be overwhelming to the mother, limits service to the extent that personnel is limited, but it does provide long-term service.

Services to the aged are viewed somewhat differently. England, which provides care to all age groups, bases the length of care upon need. There is no limit in duration, the objective being to maintain people at home as long as possible. Countries which provide services to the aging population tend to take this position:

> "It is the business of the home help to assist *invalidity* and *old age pensioners* who are in need of more permanent help. Home help is designed to enable the pensioner to live in his own home for as long as possible" (*36*). (Denmark).

Since the old age pension is a right and is not dependent on indigence, virtually any aged persons may receive home help when they need it.

> "Older people can have whatever they need. It can go on indefinitely" (*37*).

This is also the case in Sweden, Finland, and Holland, which do not limit duration in their services to the aged.

The pattern of service (assignment time) in all countries is extremely flexible. Countries emphasizing child care tend to full-time (40 hours or longer per week) assignments, since the presenting situation is usually the illness or absence from the home of the mother, employment of the father, and the presence in the home of children who need care and supervision. In England the child care service volume is small in relation to adult service. Home helpers are polyvalent in England; they shift flexibly from child care assignments to those involving the aged and infirm. In child care, however, assignments tend to meet the need.

> "We provide 40 hours of service a week, but this could stretch to 54. Where the father sleeps at home but is at work for a long day the home help meets the situation. Aside from the human factor which is important, placement of a family of five children in foster homes would seem to us far more uneconomical" (*38*).

France follows this same pattern in its program, which is primarily child care. Assignments are usually full time: that is, for a 40 hour week. Half-day assignments are occasionally made, and a 50 hour week is possible if needed.

Although there is no restriction on the hours of assignment to the aged and disabled in England, a part-time service tends to be the rule. Because of the saturation of staff, it is possible for this part-time arrangement to be geared to the individual pattern of living:

> "We are apt, with older people, to send the home help in two or three times a day. She will arrive at eight in the morning to help with washing and bathing, change bed linen and get breakfast. She (or another home help in the district) will come in to give the noon meal, or it may be delivered. She may come in to fix a cup of afternoon tea and again in the evening to get the evening meal or get the person to bed" (*39*).

This pattern of part-time or intermittent service for older people, service two to three times a week or for a few hours daily, is prevalent. All programs which serve this age group indicate that this pattern has been adopted because it appears to work well; full-time service may be provided, although programs with limited or minimal services to the aged restrict the length of full-time assignments.

Obstacles to full-time services differ in various countries; these are not invariably financial, although the funding of services lacking a reliable financial base may exert pressure in a few programs. Recently, with full employment related to rapid post-war indus-

trialization, recruitment has begun to be a problem. In England, the supply of mature women interested in part-time work appears to have diminished markedly. Germany is considering an alternate training program for more mature women beyond the required age range because fewer young women have been available; this is equally true in Holland and Belgium. Young women in France and in the Scandinavian countries view the status of the work as equal to or superior to clerical employment; and Sweden supplements the services with a substantial corps of friendly visitors.

RECIPIENTS OF SERVICE

Although all programs indicate that they serve in all age groups, the early emphasis on family life and child care has remained the basic home help program in some countries (France, Germany, Holland, and Switzerland). These tend to provide services to older persons when they are members of the family group.*

New "special problem" categories are being included in training and service programs: i.e., alcoholism, mental illness, and services to immigrants. Alcoholism and mental illness (the latter, particularly in young mothers) in Germany; all three in France, and services to massively handicapped individuals who are living alone in Belgium are later developments. There is less tendency to categorize groups in countries which have basic government funding, the service being offered generally to anyone in need.

In services to the aged, England historically made the first major approach to the problem of its aging population during World War II. By 1960, services to families with children (which had been established since 1895) were given in 74,846 families; to the aged and disabled in 214,654 families (*40*). In 1969 services were provided to about 500,000 cases, of which three-fifths to four-fifths were in the group described as aged and infirm.

All of the Scandinavian countries provide services to both groups. The development of services to aged persons in their own homes was stimulated by something more than economic considerations:

> "The description of the British system published in 1948 in a Swedish journal stimulated lively discussion among the officials, the social workers and the professors of home help training. . . . We were not even certain that they (the aged)

* The growth of an aging population in European countries has begun to affect home help services. The International Congress sponsored a seminar in 1971 which focused exclusively on the needs of the aging and extension of services in home help programs to the adult group.

really needed help in their own homes at a time when . . . homes for the aged were comfortable, modern apartments were being built for pensioners and when we believed that the majority of older people wanted to care for themselves . . . or to be cared for by their families or their friends. In fact it was doubtful that we could recruit personnel for this kind of work because of a lack of employment . . .

"Now, fifteen years after our first tentative approaches, home help for aging and invalids is so well distributed in our country, with its population of 7.7 million, that in 1965 we were able to provide (home help) service to approximately 144,443 aged and incapacitated persons (a total of 17,175,680 hours of service). Close to 8 percent of our aged population received the service. In each municipality . . . aged and incapacitated persons were helped either by specialized home helps reserved for the aged or by home helps with diplomas working full time" (*41*).

"The creation of the first home help service for aged persons is about a dozen years old. The experience has been such a positive one that no one can pretend any longer that it is a temporary activity, a palliative dictated by crowded hospices, boarding homes or hospitals, since the development witnesses to the responsibility and to the growing respect which society owes to the individual and to his liberty" (*42*).

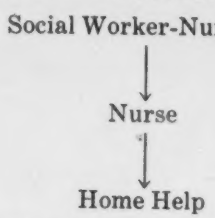
Financial Eligibility

Although there are provisions for financial participation of the family in almost all programs, *the ability of the family to pay for services is not an important element in any program.* In programs built into the social insurance system, anyone who needs the service may receive it, the costs being absorbed by state and local funding (England and the Scandinavian programs). In countries that provide government subsidy or rely upon combinations of government subsidy, private funds and selected insurance benefits, services are funded through these combinations (France, Germany, Belgium, Holland, Switzerland). In these latter programs, funding tends to affect over-all program growth rather than individual eligibility.

FUNDING, AUSPICES, AND PROGRAM DIRECTION

Wages, personnel practices, and the conditions of employment are all closely linked when the desirability of any occupation is being considered. It is impossible, of course, to compare wage

scales in other countries with those in the United States. Dr. Jonas diagrams the payment levels as follows:



Wages in France and in the Netherlands are approximately the same for home helps as for clerical workers. England pays a "fair wage" (*43*).

> "Salaries . . . are generally lower than a fair remuneration in view of the services the home help renders, the requirements exacted, and the social character of the profession" (44).

Countries which provide, through legislation and funding, for the general availability of the services usually regulate wages, hours, and conditions of employment (sick leave, vacation, travel) as a part of the general program. Hours of work and protective regulations are usually, in any case, kept fairly standard since several of the countries have established internal associations of home help services, making for a degree of standardization. Workers in countries having extensive social insurance programs (and this really includes most countries of Western Europe) are usually covered by a variety of insurance benefits; these are not so universally available to homemaker/home health aides in the United States.

At the 1969 International Congress, the necessity for further progress in the establishment of standards of payment, hours of work, protection against illness, accident, old age and vacation time beyond what is provided by "laws in force" was stressed (*45*).

Auspices

In England, Denmark, Sweden, Norway and Finland there is legislation which carries the requirement that home help services must be established in local communities. Central responsibility for the English program is placed in the Ministry of Health and in the local health authority. Funds are made available from the National Health Service Budget to each local health authority for the cost of the home help service. This pattern is followed by the Scandinavian programs, except that they are placed in the Ministries of Social Affairs (in Norway, the Ministry of Family and Consumer Affairs). Funding is there-

fore a public responsibility in all of these countries, with subventions either coming in full from the National Governments or based upon a national-local formula for cost sharing.

France, Belgium, The Netherlands and West Germany have somewhat different patterns. In France, responsibility for regulation of training and services is placed in the Ministry of Health, and the services are funded through a combination of government subventions and participatory financing by the local "Caisses Familiales" (family associations which have the status of unions and which carry a variety of responsibilities in public services and in the social insurance programs). Religious and voluntary home help programs, of which there are about a dozen, participate in the program and are governed by legislative regulation concerning training, services and conditions of employment. All are grouped in a national committee or Federation of Home Help Associations.

The programs in The Netherlands are administered by private organizations, most of them religious. Government subventions are made through the Ministry of Cultural Affairs, Recreation and Social Welfare on a formula which in 1971 consisted of 90 percent of costs for supervision, 70 percent of costs for salaries of *trained* home helps, 50 percent of the salaries of *untrained* home helps, and 85 percent of the salaries of "workers with the aged." * An additional subvention is provided for administration, with a supplement for programs having "competent" direction. Local authorities provide additional program subsidies. Subsidy preference is given to programs designated by the Ministry as "A" organizations. They are those which have a range of supervisory skills represented (nurse, social worker, professional administration) and trained home helps. Stimulation of quality through an increased ratio of subsidy appears to be an interesting and potentially successful way to improve services.

Belgium regulates training length and content by government decree in the Ministry of Health and Family Affairs, designates the minimum requirements for programs which may receive subventions (professional supervision, minimum size of staff, services which must be provided, wages and personnel practices), and provides subventions which consist of an established amount per hour of service for administration, 75 percent of the costs of social security payments for workers, and a portion of the salaries of home helps (to be fixed at 75 percent of the hourly cost after fees

* It is interesting to note that these subventions were greatly increased in 1971. In 1969 they were: 40 percent for supervision; 35 percent for salaries of trained home helps; 25 percent of salaries of untrained home helps; and 35 percent of salaries of workers with the aged (supplementary material from Dr. Scholten March, 1971).

have been deducted). Services are provided through private organizations, many of them religious.

West Germany does not have available national funding for services. Local governments, however, provide funds for home help services, and insurance benefits provide payment for services. Services are financed by a combination of these and family payments (of which only 1 percent are full fee). In Frankfurt, about 95 percent of the population is insured under the health insurance program which will pay for home help services if they are given by trained home helps. Services are provided by private agencies grouped together in an association.

In Switzerland, the Ministry of Health and Welfare regulates training, and the various cantons differ in their methods of funding services. Some are voluntary, some completely public. Public subsidies are provided when the services are administered by private agencies.

Program Direction

Program direction and supervision are almost always provided by professionals. Supervisors, "organizers," or "responsables" are drawn primarily from the fields of social work and nursing or have had experience in related helping professions. There is a two year training program for organizers in England and a similar program in Holland. France has a series of conferences and institutes, many of them focused on new or problem areas of the services. The 1969 International Congress recognized the need for "competent direction" particularly in those areas which do not assign this responsibility to professionals.

CONCLUSION

These programs which express so strongly an anti-institutional bias, appear to be only superficially based in economic considerations, although such considerations cannot be ignored as a part of the anti-institutional bias. They carry, above all, an overtone of ideological and philosophical intensity. Systematic social security has been a fact in most European countries since the 19th century: it has been an institutionalized approach to what Europeans consider the rights of individuals to at least a minimal personal security which is guaranteed by the culture and by the organized social structure. The anti-institutional stance evidenced by the serious approach to and investment in home care is another expression of this conviction.

Home care itself is a part of the social institutions of European

countries because of this essential belief in the right of the individual to protection of his "personal" self in his "own family" environment in times of stress, crisis or failing vigor.

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CHAPTER 3

The Homemaker/Home Health Aide

TITLES AND FUNCTIONS

In this age of specialization, the tendency to define functions by assigning titles which delineate differences is natural, and it is not surprising in a relatively new field to find a proliferation of titles. The functions of those to whom the titles have been assigned are usually clearly understood by those making assignments and decisions as to how one group differs from another. The uninitiated are apt to be confused by the special names assigned to persons who require training, experience and supervision, but who are not physicians, nurses, social workers, physicial therapists, public health workers or nutritionists—persons who are not "professional" workers, but who in one way or another function in relation to them.

The terms *homemaker, homemaker/aide, home health aide, health aide, home nurse's aide, physical therapy aide, community health aide, visiting housekeeper, teaching homemaker* and *attendant*—and perhaps a dozen more terms in the process of being designated—differ in definition from program to program and from community to community. These terms appear to satisfy the special purposes of the involved—and mystify the ignorant. The definition of an *attendant* in one community is different in another; and the definition of the functions of a homemaker, an aide or a housekeeper in a single community may be reversed in different agencies.

We make constant reference here to the terms "agency," or "program," and this has a special meaning for us. Yet to many, the word "agency" implies an employment agency; "training program," a school established for private profit. From both of these sources, personnel emerge, causing further confusion; some are titled or certificated but unlicensed: i.e., "practicals," "nursing assistants," and companion-nurses for the "elderly."

Origin of Titles

The origin of some of these titles may indeed have been valid. *Attendants* have been designated in some of our public agencies,

and are generally accepted there as a category of personnel hired by the consumer of service; usually as a kind of general assistant in the home, untrained and unsupervised, and most often used by aged persons who have a multiplicity of needs. However, some voluntary health agencies and rehabilitation institutions use the same term to describe a highly trained non-professional, capable of performing an astonishing range of services for the severely handicapped person at home: care of patients in respirators, skill in the use of catheters and tracheotomy tubes and other similar services.

The term *home health aide* first received common acceptance in the Federal Medical Assistance to the Aged program, and later in the health insurance program for the aged. In both instances it was intended to establish the firm relationship of the service to medical need. However, some communities have used such personnel as another version of the hospital aide, providing a range of complex services almost interchangeable with those of the professional. In others, they have been used to provide a service limited to what is usually taught in simple home nursing courses.

Certain titles have been adopted locally to attempt to describe the focus in the setting: i.e., the *teaching homemaker* in the Welfare Department, where the emphasis is upon improving child care, sanitation, nutrition, household management on a limited budget, and the utilization of surplus foods. The term *homemaker* has often meant that a family agency is the employer and services to children the focus; and the word *aide* itself has tended to mean either services provided in a health setting or emphasis on personal care. The *homemaker/home health aide* combines many of these activities, which she may perform in a variety of agency settings providing services in the home.

Training for Service in the Home

In spite of this variety, many of the training programs which have been effective in preparing non-professionals for service in the home—whether for care of the sick, of children, or mainteance of the enfeebled aged—have tended to be similar, probably because the needs of those requiring such services are similar. Even when more technical skill is needed to perform a service, training programs are built upon a common base; this, too, is probably because the basic needs of those using the service continue, regardless of the need for special skills.

This characteristic of services provided in the home is important in selecting the kind of personnel needed, the skills required, and the responsibilities of those who make the services available. Non-professional personnel are used in a variety of ways in

institutional settings; there are those who commonly express the belief that the skills of persons trained for institutional work can easily be transplanted to the home without any special effort (i.e., further training). The major difference between training for institutional work and training for work in the home is that whether or not supervision is constantly exercised in an institutional setting, it is always available. This fact has caused considerable concern whenever there is discussion of assigning any but the most limited tasks to non-professionals who are to be employed in situations where continuous supervision is not available.

The major reason for requiring services in the home, in this country and abroad, has been illness with its attendant problems and needs: either acute illness requiring convalescent care, chronic illness requiring support for longer or shorter periods of time, or physical disability necessitating continuing services. Where physical illness has not been a primary problem, family dislocation, necessitating attention to the needs of children; mental illness; retardation; extreme deprivation have brought about situations which usually require many of the same skills, ranging from maintenance of the environment to some of the very skilled services in the care of the sick which have been mentioned above.

Situations Requiring Care in the Home

In general, what characterizes all of these situations has been, first of all, that there is no member of the family or individual in the home capable of performing the needed tasks. Second, there has been no person in the home capable of recruiting, training and supervising an employee in the performance of these tasks. Third, the needs that exist are not of a nature requiring institutional care—although they do require a planned therapeutic program and, often, specialized skills.

There are two further distinguishing characteristics of services provided in the home. First, contact between the worker and the family is necessarily an intimate one, which is not usually the case in institutional care. This intimacy can be fraught with difficulties and irritation unless it is understood. The second is its positive aspect, the constructive potential inherent in the presence of a skilled but non-professional worker, who can be used supportively. The non-professional worker in the home can be a strong source of emotional support, and can become the carrier of essential knowledge and information in ways that are not always possible for the professional. Often communication is simpler and new ideas are, in consequence, more readily accepted.

The hospital aide has been taught specific skills. In addition to these, she has been trained to approach the patient in a pleasant,

cheerful and understanding frame of mind. These contacts, however, are intermittent; and her observations are always supported by a professional person who is readily available. The worker who performs these same tasks in the home, however, is in more continuous contact with the recipients of her services; in addition to the physical tasks which she performs, she is called upon to use considerable independent judgment and to make careful observations. She must be capable of establishing a relationship with both children and adults in which intimacy, restraint, warmth and objectivity are combined. These are some of the reasons which place upon the agency providing the service the responsibility for careful selection, for a unique kind of training, and for a unique kind of supervision involving, as it does, so much dependence upon what is taught and learned.

Definition of Terms

The term *homemaker/home health aide* brings together under one title a wide range of characteristics, responsibilities and activities. It describes an individual who has been selected because of temperamental stability and the capacity to relate to others with warmth and understanding. The title is acquired through a process of training and supervision in an established agency with a defined administrative structure, staffed by professionals who carry the responsibility for each home care plan in which the homemaker/aide functions as one component.

The term *agency* refers here to an administrative structure financed either by tax funds, private funds, or a combination of both. It is organized for the purpose of performing specific functions and providing specific services in order to meet needs defined by law or policy. In homemaker/home health aide services, the agency is responsible for the personnel employed to perform defined functions, or provide services; it defines the conditions in which they are provided and the methods used.

The *program* of the agency describes its objectives, its scope, and its array of services. It may also describe a community program to which the agency is related as a part of a total program.

Non-professional or *paraprofessional* is used in homemaker/home health aide services to describe personnel who may, initially, be untrained or unskilled. They are employed by the agency which provides the necessary training and supervision so that they may perform specific tasks in the homes of recipients of agency services. They carry out that part of the treatment plan which is appropriate for non-professionals.

The terms *home care* or *in-home* services are used to describe any service or combination of services provided in the home to

sustain, maintain or supplement the essentials necessary for optimum health and personal security, in situations brought about by any single factor or combination of factors related to illness in individuals or families, or to situations of stress which require such supplementary services.

THE AGENCY SETTING

Homemaker/aide services of good quality are provided by private family service agencies, visiting nurse associations, public welfare departments, public health departments, organized home care programs, and independent agencies developed specifically to provide such services. The choice of setting, although it has been the occasion for considerable discussion, has had less to do with the quality of the service than the presence or absence of elements in the program which are necessary to the provision of good service. A structure which places emphasis on both health and social needs; supports its homemaker/home health aide staff with interested, qualified professionals, and develops and sustains an atmosphere in which confident attitudes and mutual respect between professional and non-professional personnel are always evident, is the essential setting for services of good quality.

Common Employment Misconceptions

There is a common misconception concerning the suitability of employing unskilled workers as homemaker/home health aides. It is argued that those who are initially unskilled or under skilled lack the potential for this work. This argument is based upon the assumption that: 1) the unskilled do not want to do this kind of work, even if they are in financial need—they would "rather stay on relief"; and 2) the chronically unemployed are not culturally or intellectually suited for the necessary training and service.

These assumptions are not valid and must be eliminated as considerations in the selection process. In the past, the circumstances of so-called attendant or aide employment available in the open labor market have been such that the intelligent course was to avoid such work if there were other alternatives. This does not imply a resistance to the work itself. Those who have undertaken to do "day work," to accept employment in the homes of the severely disabled or handicapped, or to attempt work in numerous small boarding homes, rest homes and similar institutions, have been placed at such a disadvantage that any alternative becomes both necessary and desirable.

Difficulties for the day worker attempting to develop an independent employment pattern are great. The work is usually

casual; that is, it is offered without guarantees as to continuity and quantity. Hours and days are changed, and service is discontinued for weeks or months without notice, then resumes again without notice. The independent worker can expect neither minimum wage guarantees nor personal protection on the job.

Similarly, the independent worker who accepts employment to care for elderly or disabled individuals on a full-time basis is often expected to assume total responsibility, to be available on a 24-hour basis with little relief, and to provide services for which neither training nor supervision are available and which require skills ordinarily assigned to professionals. Workers who go into full-time live-in child care situations are similarly burdened. The "light housekeeping and care of small children in return for a cheerful room, board and small salary" often means hard and continuous labor—with child care, heavy housework, laundry, shopping and cooking a normal part of every day's routine. Payment for this heavy, exacting and responsible work is rarely even in the minimum wage bracket.

Room and board are often assumed to make up, in large part, for the lack of financial return, although the worker in these situations must usually also maintain some kind of independent housing. The "cheerful room" is generally makeshift, more often inadequate than not. Personnel turnover in the small institution or boarding home is very high. Frequently the assignment is 24-hour total care for a group of senile, incontinent, bedfast or minimally ambulatory patients, with very little supervision available, constant shifts in schedule, and a general atmosphere that is therapeutic neither for the patient nor the employee. The financial returns are usually commensurate with the concept that despite these pressures the person is "unskilled" and wages should therefore be minimal.

Thus, the individual who attempts to organize his own employment program in this type of work is at a great disadvantage, with no guarantee of financial security, acceptable working conditions, nor continuity of employment. Although the comment is constantly made that it is impossible to find people who will work in situations of this kind despite widespread unemployment, it is not surprising that the conditions which prevail do not compete successfully with public assistance—which *does* at least offer the minimum guarantee of continuity and a practical approach to subsistence needs.

Cultural handicaps are frequently seen as obstacles to employment of persons drawn from the reservoir of the unemployed and underemployed. However, these must be looked at in the context of the unrealistic expectations that prevail in the labor market.

The expectation that all individuals seeking employment must possess from the beginning a wide variety of skills, many of them semi-professional, in order to obtain employment is unrealistic. Furthermore, the expectation that such individuals must be capable of fitting into situations which have not been evaluated, and in which the needs have not been realistically defined, is manifestly unfair. It is usually also expected that every prospective employee be literate, neat, often uniformed, punctual and "intelligent" (that is, fitting independently and usually without instruction or supervision into all situations as they arise); that the employee, without preparation or support be emotionally capable of maintaining a cheerful mien regardless of all difficulties in the objective situation; and that the employee be physically strong, not too young, not too old, and fit for heavy labor in addition to all necessary skills. The objective seems to be to find an inexpensive but ideal substitute for what cannot be afforded.

It should be obvious that all of those who qualify in the above respects will already be in preferential employment. It is the proliferation of failures that has created the stereotype. Failure has also undoubtedly instilled in many an intelligent and willing worker a sense of hopelessness, since its roots lie in employer expectations which are at best unrealistic, and which at worst perpetuate employment situations that constitute cruel and inhuman treatment.

The major distinction between the organized agency program and the chance situation, with respect to the use of untrained personnel in the open labor market, is that initial expectations will differ. The purpose of training and supervision is to develop necessary knowledge and skill and to provide for the worker what is commonly accepted as standard in all other working situations.

It should be said, therefore, to those who have not used non-professional personnel in this kind of service, and who have questions about safety, teachability and quality, that given the essentials of a good setting many of these reservations will disappear. The ability of previously unskilled personnel to accept and use training; to relate positively to supervision; to serve with intelligence, sympathy and good judgment and to acquire an ethical approach, has been demonstrated. Agencies in this country and abroad which have developed programs of this kind usually describe their experiences as a series of happy and stimulating discoveries.

The isolation of the professional within the boundaries of her own special field, and the mistrust which the initially unskilled worker has for the professional, may be barriers in the beginning.

As the two groups meet in mutually shared experiences in training, supervision and service, a new set of relationships develops. The acquisition of new skills and insights by the non-professional brings an assurance which supports the expression of natural attitudes, freshness and immediacy of observation and concern. These in turn call forth a genuine respect and appreciation from the professional who has helped to make such development possible.

CHAPTER 4

Agency Policy and Services

At its best, policy expresses the aims and objectives of the community in a manner which makes for appropriate use of the service and which supports the staff in its efforts to provide effectively for community need. Clearly stated policies in homemaker/home health aide services protect the essential function of the services and are a good guarantee against misunderstanding in the community and confusion in the staff. "Rational" policies reflect practical understanding of patterns of service, and an approach which is broad enough to allow for both sensible independent judgment and the "exceptional" case, which should not be ignored whatever the policy.

Although not all policy is developed prior to the organization of agency services, a general statement is almost imperative. This is usually the product of the assessment of community need (although it may be modified at the outset by the need which the community *perceives* as its first priority, not always synonymous with assessed need). It may be affected by special agency interest; it will invariably be affected by agency capability in the areas of budget, staff and geography.

Policy Formulation

The delivery of consistent services will depend upon the formulation of rational policy, followed by practice which effectively implements that policy. Agencies vary considerably in their method of policy formulation. Some insist upon a detailed written statement which attempts to foresee and regulate all eventualities. This is an effective protection for the service, except in those instances where flexibility might ensure better quality. Other agencies prefer a general statement of agency goals and hope within a broad framework, to develop varied patterns of meeting need. Trust in those who provide the service to use imagination and judgement is often amply justified. However, the range of individual reaction can end by producing services which are erratic, and do not fulfill the expectations of the community. The best approach to policy formulation lies between the extremes of

exact regulation on the one hand, and a "flexibility" which may become formlessness, on the other.

Whether it is specified in detail or stated generally, policy is usually formulated with respect to:

1 The groups(s) for whom the services are intended;
2 The conditions which are necessary for acceptance;
3 The services, in range, scope and duration, that will be provided, and their limitations;
4 Regulations which safeguard the provision of effective services.

THE GROUP(S) FOR WHOM SERVICES ARE INTENDED

Some agencies have been established with the broad objective of providing services to any individual or family "in need." However, as the services develop and caseload pressures begin, the term "in need" may require considerable clarification. In order to narrow the policy with respect to those accepted, the agency may single out certain groups (i.e. by age, economic status, presenting problem, geographic location). It may, by policy, accept all of those in need, but establish guidelines which distinguish those "at risk" from others whose need may be present but less pressing in terms of agency capability.

Selecting Aspects of Need

Agencies, and the communities that support them, may select more circumscribed aspects of need. The primary objective in many agencies has been the "support of the family in crisis." Here the concept of "family" is intended to mean groups of related members, usually with minor children, living in the same household; and a "crisis" is defined as any circumstance which threatens the unity of the family group. This may be more specifically defined in policy: i.e., families where there are minor children and where parental supervision is not available because of physical or mental illness; families in which the pressures of child care and home management have become overwhelming for the parent; or families in which the pressure of care of a handicapped child or adult is overwhelming, and the need for supplemental help and support have become essential.

A second selection more recently developed has been one that centers upon "the chronically ill and aged" or on "health related" need. Here the objective is to provide in-home services to those members of the community who, because of certain physical limitations, illness or disability, are in need of health care, cannot

fully maintain themselves in their own homes, but who are not candidates for institutional care. Although they do not need the combined specialized services of the institution, these individuals may require single services or combinations of services which are therapeutic, and which combine health care and general supervision with assistance in activities of daily living and home maintenance. More specialized programs may offer services to those who are in need of care at home because of mental illness, because of problems related to alcoholism or drug addiction, or as a part of a specialized physical rehabilitation plan.

Programs which focus primarily upon adults frequently use the term "family." This may be misleading since, by policy, services may also be provided to those who live alone. Programs which serve such adults usually define the "eligible family" as a household comprised of one or more individuals who wish to maintain a home; who are unable, independently, to perform all of the functions necessary for their safe maintenance; who require therapeutic services which may be provided effectively in the home; who do not have access to employment sources, or who are unable to recruit, train, lay out a plan of work or supervise assistance brought into the home to perform these functions (usually because of illness and/or disability); and who could be safely maintained in the home if supervised assistance could be provided.

The answer to the question "who will be served"? need not be narrowly defined; it may allow for considerable flexibility. It should, however, be presented in such a way that the agency staff and community understand the *central focus* of the agency's intention.

CONDITIONS NECESSARY FOR ACCEPTANCE

Once policy has been established with respect to those whose care will be the primary focus of agency concern, it is necessary to further define the conditions that govern or qualify acceptance for service, so that services may be safely and effectively provided. Inevitably, judgment will be necessary in applying them. An "appropriate" home means different things to different people. The judgment that a home care plan is "feasible" may be open to question, yet factors may be present which may make for "feasibility" in one situation and not in another.

The establishment of policies concerning acceptable circumstances will, however, help to guide referrals, clarify the purposes of the services to recipients, and provide the staff of the agency with a standard upon which evaluation can be based. Conditions for acceptance usually include consideration of:

1 The "appropriateness" of the home; i.e., "feasibility";
2 A requirement that a "responsible" family member must be available, or the absence of such a requirement;
3 The attitudes of the individual and/or family members toward acceptance of recommended home care;
4 The availability of health supervision; the health status of recipients;
5 The availability of the range and volume of services needed in order to make home care effective.
6 Financial eligibility.

Appropriateness of the Home "Feasibility"

Home care plans may be developed even under the most difficult circumstances. They have been developed and maintained in hotel rooms, in primitive rural housing situations, and in inconvenient and crowded urban slums.

If, however, a post-operative ulcer patient is in need of frequent feedings and his "home" does not have adequate cooking or refrigeration facilities, it is inappropriate for his care. A patient with limited ambulation whose bathroom must be reached by climbing a steep flight of stairs is not appropriately housed for home care. The availability of heat, light, and those facilities essential to the present circumstances of his need affect the decision as to whether or not his home is appropriate for his care.

"Feasibility" is based upon professional evaluation, which relates the situation of the applicant in his environment to the capability and availability of staff and services. It may be possible, for example, to maintain a massively handicapped individual in his own home, given the availability of a range of specialized services to maintain him; to provide in-home services to a parent with a large number of children, several of whom are ill and one of whom is deeply disturbed, given the availability of staff adequately trained for this purpose; or to maintain a fragile, semi-ambulatory adult who lives alone, given the availability of services at crucial times, and/or reliable supportive services from neighbors, friends or relatives to ensure safety.

The guideline upon which feasibility is based has to do with the answer to the question: "Can the person(s) be maintained in a home care plan in safety and with the possibility that stabilization or progress toward therapeutic goals can be achieved?"

Responsible Relatives

The availability of "responsible" persons—i.e., family members or relatives—as a pre-condition of service is the stated policy in many agencies. In child care cases, availability of a family mem-

ber after working hours may be one of these (although effective services have been provided when agency personnel can be placed on a "live-in" basis for specified periods of time). This requirement is sometimes imposed in services to adults, even when evaluation might indicate that the recipient is capable of self-maintenance during periods when agency personnel cannot be in the home. In these instances, such a requirement becomes difficult to justify: it will, in fact, eliminate many who could effectively use the service. It is probable that this requirement is based upon traditional patterns carried over from the child care orientation of homemaker/home health aide services. It may also reflect the agency's lack of security in assuming responsibility in place of relatives who are not available. In any case, where this requirement is a policy the agency must define its meaning. What is meant by a "responsible person"; and what is the extent of the "responsibility" which is to be assumed?

Attitude of Recipients

An important condition—or consideration—is the attitude of the recipient(s). Whatever the physician, nurse, social worker, or others outside the family may think, home care plans are rarely effective if the recipient of service is so insecure that even a feasible home care plan is unacceptable. Families who resist or resent the pressures involved in maintaining a disabled family member at home will not contribute constructively to his care. Trial periods of service may eliminate such attitudes. If they do not, wise policy is to offer alternative plans which are acceptable to the recipient and his family.

Health Supervision and Health Status

A large number of those in need of homemaker/home health aide services have problems related to health—acute or chronic illness, physical debility, emotional disability, or in the case of very deprived family groups, multiple problems in which health is almost invariably an important element. The requirement that medical supervision must be available in these situations is essential. This, of course, becomes an arbitrary requirement in public or private health insurance programs which provide payment for services, and in agencies which focus primarily on health care. It is a requirement in all homemaker/home health aide service programs when they are part of health care agencies.

Agencies which are not primarily serving groups whose presenting need is illness sometimes fail to see the necessity for this requirement. When continuous health supervision is not one of the conditions of service, an important factor in the success of the

home care plan is overlooked. The quality of the service may then be seriously affected, since an important objective in the delivery of the service is to bring all individuals in the home to optimum physical (and psychological) health.

Policy concerning the health status of applicants is usually based upon the range and volume of services available in the agency. Some programs will accept semi-ambulatory but not bedfast patients (this may be qualified by considerations such as other available sources of assistance, and the projected outcome of the problem); others will accept relatively immobile patients who can be taught with rehabilitative techniques to become self-sustaining in daily living activities. Agencies with limited resources for health supervision, or with a staffing pattern which does not allow for easy accessibility to supervision, may establish acceptance policies which offer services only to those whose health problems are minimal and whose needs are mainly supportive (i.e., social and environmental support, nutrition, observation).

Policy with respect to communicable diseases varies. Some agencies may not accept patients with the diagnosis of tuberculosis in any stage; others will accept most homebound tuberculous patients; and still others avoid all communicable health problems. Such policies are not usually the result of caprice or frivolity, though they may occasionally be the result of limited knowledge of the implications of various communicable diseases. Most often, however, they are related to a careful examination of agency capability, with respect to the training and supervision of staff, in order to provide services in a manner which will protect both staff and recipients.

Financial Eligibility

Financial considerations are frequently either stated or implicit in the conditions which are part of agency policy. Most agencies avoid arbitrary statements of policy about family financial participation in the plan, preferring to describe the service as one which is provided on the basis of "need." There are, in fact, agencies which do not provide service unless there is full reimbursement, either by the recipient or through third party payments.

Voluntary agencies, which must rely entirely on charitable funds or individual fee-for-service, may not have adequate resources for part-pay or free services. Many of the most effective agencies are those which establish the policy that they will provide for families in a variety of economic circumstances: full reimbursement, part-pay and free care. When funds are limited, such agencies accept only those families which can be continuously served for the duration of their need. By policy, services are thus

provided on the basis of need alone to that number of families which the agency's budget can support. "Unmet need"—i.e., those applicants who cannot be accepted because of agency budgetary limitations—can then become a demonstrable problem to which the attention of the community is directed. Policy concerning financial eligibility should be frankly presented so that the community does not begin to think the agency has apparently promised care it has subsequently refused to give.

RANGE, SCOPE, AND DURATION OF SERVICES

A full range of services could, in the most comprehensive sense, include many which are probably not available in any homemaker/home health aide program in the United States. At present, the services most frequently provided are professional nursing, professional social service, and physical and occupational therapy in addition to homemaker/home health aide services. Some agencies also offer nutrition services and speech therapy. There is, rarely, an associated "meals on wheels" service. The "blitz clean," or mobile janitorial services for major rehabilitation in problem homes, is an important service in some European programs but is not provided here. Equipment and transportation are rarely provided.

The general pattern in the United States has been a combination of social services, with homemaker/home health aide services in programs which emphasize child care, and nursing services combined with homemaker/home health aide services in programs which emphasize health care. Health insurance programs have stimulated the addition of physical, occupational and speech therapies; and in most health related programs, medical social services or social service consultation.

Policies defining the range of services should specify those for which the agency is directly responsible, either by employment of the necessary personnel or by contract or purchase on behalf of the recipient. Services which are "available" in the community but which cannot be provided on demand should be understood as such.

Assignment Patterns and Duration of Service

The "pattern of assignment" refers to the scheduling of homemaker/home health aides in the home:

—Will homemaker/home health aides be assigned only part-time?
—What is the definition of part-time?
—Are daily part-time assignments to be made or will they be intermittent?

—Are very short assignments (one or two hours) permitted?
—If full-time assignments are to be allowed, will these be limited to the working day, or are 24-hour assignments possible? If the latter, may such assignments be extended or limited to emergencies?
—What are the requirements for sleeping arrangements when 24-hour care is provided?

The "duration of service" refers to agency responsibility over various time periods:

—Will services be continued over periods of weeks, months, or in relation to need?
—Is the service to be limited to acute care need, or will services be considered valid when the need is for a rehabilitation or support program over an extended or indefinite period of time?

Such policies will be affected by the resources of the agency; these should be defined in statements to the community.

Professional Services

The stated availability of a given range of services can lead to considerable confusion if they are not further qualified by agency policy. This confusion may be present in the staff as well as in the community.

One of the distinctive aspects of homemaker/home health aide services is the duality of the professional role. This may be further complicated by the necessity for an interdisciplinary approach. This dual professional responsibility includes provision of *direct* service to the patient (the application of skills which are integral to the particular professional competence); and the *supervisory* function (in which the professional assumes responsibility for the activities of the homemaker/home health aide). This may include more than the word "supervision" usually implies, since it involves implementation of the home care plan (or at least part of it) *through* the skills and services of the home health aide. It also involves the maintenance and, ideally, the consistent upgrading of the skills of the aide. These cannot be seen as a set of parallel influences flowing from nurse, social worker, therapist or nutritionist to the homemaker/home health aide. They must be merged as a total interdisciplinary approach at the professional level if they are to be merged through the homemaker/home health aide at the delivery level.

Policy, therefore, will necessarily emphasize three aspects: 1) the range and limitations of the *direct* services of the professional staff and of the homemaker/home health aide; 2) the range and limitations of the individual professional *supervisor* of the home-

maker/home health aide; and 3) the established mechanisms for an *interdisciplinary* approach to the total plan and to the homemaker/home health aide. This is not to suggest a system so mechanical that there can be no overlapping; flexibility and occasional shifts in responsibility will occur with good effect when mutual understanding and trust has been developed.

Professional supervision of the homemaker/home health aide involves the assumption of full responsibility by the professional for the activities of the homemaker/home health aide. Because this responsibility is assumed during periods when the professional is not physically present to oversee these activities, guarantees of safe and effective performance can only be secured by a process of training, observation and the security achieved by continuous interaction between the homemaker/home health aide and the supervisor. This interaction is based upon policies which define the roles of both supervisor and homemaker/home health aide.

The supervisor:

—is familiar with the temperament, the skills and the limitations of each homemaker/home health aide, and places each aide in situations in which she will perform most effectively;

—instructs the homemaker/home health aide in every assignment, outlining the specific tasks to be performed, observing the performance at necessary intervals (which will vary depending upon the capability of the aide and the nature of the assignment) to determine that the assignment is clearly understood and the performance effective and consistent;

—assists the aide in her relationship with the recipient and his family, describing and explaining the attitudes and behavior which she will encounter and suggesting responses which will help the family to make maximum effective use of the services;

—supports the aide in difficult situations so that she can tolerate such difficulties in a calm and understanding way;

—emphasizes physical and/or emotional changes which indicate that professional attention is needed, and encourages the aide to act promptly to secure professional help by giving specific instruction on how to secure professional assistance at all times;

—establishes a methodical procedure for regular reporting on the status of every recipient, and for regular conferences with the aide, singly and in groups;

—encourages free discussion, expressions of insecurity and doubts, and questioning, and responds in ways that increase the confidence of the aide and enhance her ability to use supervision readily;

—repeatedly reviews and reinforces agency policy in general and with specific reference to each treatment plan.

When this pattern of supervision is well established, the homemaker/home health aide will:

—follow her assigned duties in the treatment plan precisely, and act independently only in those instances which have been specified by her supervisor;

—freely request review of the outlined plan or assistance with procedures when she is in doubt, and use supervision whenever it is necessary to help her deal with interpersonal difficulties which arise in the home;

—carefully observe the status of those in the home and report all changes promptly;

—respond calmly and according to planned procedure to all crisis situations;

—adhere implicitly to the policies and regulations of the agency, and respond invariably to the supervisor with confidence and with a clear recognition of her professional and supervisory role.

HOMEMAKER/HOME HEALTH AIDE SERVICES

Confusion may arise in the staff, the recipients of service and the community about the capabilities, duties, skills, and responsibilities of the homemaker/home health aide. The professional who has not worked with trained, non-professional personnel is apt to be mistrustful and to resist the idea that certain services can be performed by the aide in the absence of direct and continuous professional supervision. Or, the professional assumes that any activity which *appears* safe can, as a matter of course, be undertaken by the homemaker/home health aide. Recipients of service, the community at large, and sometimes the physician either mistrust the capacity of non-professional personnel, or fail to see why seemingly simple procedures cannot be undertaken by the aide upon demand or prescription. The aide, herself, may be affected by opinions of others, or by her own reservations or overconfidence with respect to activities she may undertake. Thus, it is of the utmost importance that agency policy be spelled out in considerable detail; be included in written program descriptions and in information given both to the recipient of service and to the staff; and be subjected to continuous surveillance to ensure consistent adherence.

Such policy will describe the *general* scope of services, and will cover the provision of the following services: personal care,

household maintenance, food preparation, menu planning, preparation of special diets, food purchase, incidental services (i.e., accompanying recipients on walks, to medical appointments, on shopping trips), and other services on behalf of the recipient. Policy will also cover *specific* limitations within the general scope of these services.

Personal Care

Personal care has been a key issue in the development of homemaker/home health aide services. Whether or not a non-professional is capable of providing services that involve *physical* care of the sick has been repeatedly debated throughout the history of homemaker/home health aide programs in this country. The fact that such services are provided by a non-professional in a setting (the home) in which continuous on-the-spot professional supervision is not available (as it presumably is in an institutional setting) has been the source of much of the concern about "personal care" services.

Several factors—related both to necessity and experience—have influenced national policy with respect to such services. Necessity stems from the requirements of those who are considered appropriate candidates for home care: individuals who are usually sick, who may not have family members available to provide personal care services, and for whom institutional care is inappropriate. Experience has shown that given the essential conditions (selection, training, supervision, and sound agency structure), homemaker/home health aides have in fact provided personal care services safely and effectively.

An influential factor has been the inferred approval provided by the government insurance program, which includes supervised homemaker/home health aide personal care services as a reimbursable cost.

Another factor is innate in the service itself. Few agencies have been able to maintain viable homemaker/home health aide services when they have been unwilling to allow the homemaker/home health aide to provide personal care, since the need for personal care may occur at any time when the homemaker/home health aide is in the home. It is impractical to expect that professional help will be immediately available. The stricture against "touching the patient" is difficult if not impossible to sustain under these circumstances. Policy, therefore must be specific concerning the *extent* of personal care services to be provided by the homemaker/home health aide, and amount of supervision and training essential to safe performance.

The allowable personal care services vary considerably. Agency

policy ranges from assistance with washing and dressing to the provision of care services which reach at least the lower ranges of vocational nursing activities.

Limitations in Personal Care

The decision to allow the homemaker/home health aide to provide personal care services is not in itself an adequate guarantee of safe, effective service. Specific limits must be established and understood. Personal care policy for the homemaker/home health aide must be based on provision of only those services for which the agency is prepared to take full responsibility. Such responsibility can only be assumed when adequate training has been given to cover all allowable activities. Aides who provide personal care must have been selected for their sense of responsibility, their demonstrated good judgment, their reliability, and their capacity to adhere closely to the regulations concerning these activities. Furthermore, aides who provide personal care must be supported at all times by adequate, available and responsible professional supervision.

The most frequently provided personal care services, in addition to simple personal hygiene, are: assistance with bathing (helping semi-abulatory patients in and out of tub or shower); providing bed baths; changing bed linen with patients in bed; shampooing of hair; taking and recording pulse and respiration; transfer activities (in and out of bed, bed to chair or wheel chair); assistance with ambulation; assistance with toiletting (bed pan); simple prescribed exercises; and making available (but not administering) prescribed medication.

Less frequently provided personal care services are: use of special equipment (hydraulic lift); simple dressings; more complex prescribed exercises; and assistance with braces and appliances.

Policy with respect to personal care services is invariably reinforced by an individual patient care plan based upon physician's orders, and evaluation by the professional staff of the agency. Agencies which have established precise limits in policy—in conjunction with careful selection, assignment and supervision of the homemaker/home health aide—have demonstrated impressive success with personal care services. Needless to say, these services are an important extension of professional capability and allow for maximum utilization of staff.

Household Maintenance

"Light housework" has become, to a large extent, the euphemism behind which many agencies conceal their refusal to provide home

care. "Light housework" usually covers services of the type provided by a licensed vocational or diploma nurse employed by the family: care of the patient's bed and the area around it, light dusting, care of the patient's eating utensils, and light personal laundry (the patient's nightgown, underwear, an occasional blouse, shirt or housedress).

Adherence to such a policy denies services to those individuals or families who have no one available to perform maintenance duties, and who lack the financial capability to employ someone for supplemental maintenance service. It is generally accepted that *essential* maintenance services in families in crisis—or in families having one or more ill or infirm individuals and no supplemental maintenance services—include the following:

—care of the patient's room with periodic thorough cleaning (sweeping, vacuuming, dusting);
—care of kitchen (general cleanliness with periodic thorough cleaning of refrigerator, stove, and sink, and mopping of floor);
—care of the bathroom with regular and thorough maintenance of cleanliness of toilet, tub and shower; periodic mopping of floor; and
—care of laundry: personal laundry and preparation of linen for commercial laundry service, or periodic use of automatic laundry equipment.

With training in labor saving techniques, and with careful planning and scheduling of homemaker/home health aide time, such a general maintenance program can be provided in part-time assignments and without undue physical strain. The inclusion of such services may effectively use homemaker/home health aide time when personal care tasks, which occupy only a portion of the allotted time, make scheduling of assignments for short periods impractical.

Child care agencies may go far beyond the assignment of "light housekeeping" duties, although they may maintain the "light housekeeping" fiction in stated policy. These agencies more usually expect that the homemaker/home health aide will take over virtually all of the duties of the regular homemaker. This may include the washing, ironing and mending of children's clothing and occasionally those of an employed adult); maintenance (at least partial) of children's sleeping quarters; and the general maintenance of the total household. It is important to teach homemaker/home health aides how to raise the general standard of living in deprived households—how to work with the regular homemaker in all household activities in an effort to establish and maintain a pattern of efficient and hygienic household management.

Virtually all agencies do establish definitions of work and/or

methods of work which they consider "heavy" housework, and these are prohibited by policy. These include such activities as window washing; floor waxing (some agencies prohibit care of floors "on hands and knees," but not with mop, broom or special equipment); wall washing; washing of curtains or drapes; "heavy" hand laundry (i.e., hand washing or hand ironing of sheets, pillow cases, table linens, or blankets); and care of linens for incontinent patients (frequently considered ineligible for service). Agencies sharply limit responsibility for household maintenance in large homes (although this is more frequently established in the individual care plan). They also prohibit, by policy, those activities which are considered unsafe; i.e., adjustment or repair of electrical equipment, cleaning or adjustments which must be done by climbing on chairs or ladders, carrying heavy objects, and moving heavy furniture or equipment.

These policies, with respect to maintenance duties, are stressed in homemaker/home health aide training, in general interpretation to the community (with the understanding that such policy will, to some extent, affect eligibility), in information leaflets to users of service, and as a rule, in specific duties spelled out in the individual care plan. Usually homemaker/home health aides are not expected to enter into discussions about what they cannot do. When recipients ask for assistance with tasks that are not allowed, they refer the request to the supervisor, who makes the necessary explanations. This way, misunderstandings about unwillingness to cooperate are not viewed by the recipients as faults in the homemaker/home health aide; but are rather understood as agency policy for which the aide is not responsible. Exceptions, when they are made—and they are, in most flexible agencies—may then be defined as such and carefully qualified by professional staff.

Food Management and Food Preparation

Meal preparation has always occupied a central place in the range of duties considered appropriate for the homemaker. In child care programs particularly, good nutrition—the "caring" aspect of food preparation—has been strongly emphasized. With the growth of services to adults, there has been a tendency in this area, as in the area of household maintenance, to limit homemaker/home health aide activities. Emphasis in many instances has been placed on the nutritional status of the *patient*. However, a frank approach to practical considerations in meeting the family's general dietary needs is always the most productive; and the narrowing of homemaker/home health aide responsibilities could well be considered a step in the wrong direction. If agency

policy limits the aide to invalid cookery, with the expectation that "others" (relatives or other "responsible" persons) will be responsible for the provision of necessary supplies, this will eliminate from eligibility many chronically ill and disabled adults who live with similarly disabled family members. Community awareness of the implications of the policy is important.

A more general approach would include the following: regular purchase of basic food supplies essential to good nutrition for the recipient and, usually, the "family" (if the family is small, i.e., spouse or other physically limited members of the family); or for dependent children and, perhaps, an employed adult. This, of course, would be based on the condition that no other adult could reasonably be expected to assume this esponsibility. Such purchase may be made under the direction of the recipient or a responsible family member; or may be assumed, if the home care plan requires it, as an independent responsibility of the homemaker/home health aide. The latter is clearly necessary in child care, when the mother (or person who assumes the homemaker role) is ill, absent, or has limited competence. It may be less necessary when the recipient of service is a fragile older person. Here, the assumption of independence by the homemaker/home health aide would be made only on the basis of professional evaluation. The acceptance of responsibility by the recipient or family —at least for planning and direction—is frequently an important rehabilitation goal. Practical considerations (planning, budgeting, sound marketing) will, of course, be an important part of homemaker/home health aide training.

Homemaker/home health aides are not, however, required to carry large or heavy grocery orders, or to walk long distances to purchase supplies. Scheduling of shopping assignments, use of adequate transportation facilities (taxis when necessary), and supplemental aids such as shopping carts or, where possible, delivery services, are usually a policy requirement. Frequent and unplanned "errands" upon demand are avoided. The policy that only one shopping expedition is allowed during a single day's assignment is usual.

Regular Planning and Preparation of Meals

Food preparation and the serving of meals which meet the basic nutritional needs of the recipient and his "family" (as defined) is a usual part of the homemaker/home health aide assignment. This does not necessarily imply the presence of the aide at all meals. In practice this is rare, since full-time service may not be generally available. It does involve the planning of meals with purchases related to such planning; convenient storage and arrangement of

supplies; and preparation of foods so that they are available for the recipient and family when the aide is not in the home. Usually, the aide's schedule is timed to provide one hot meal, (casseroles or pre-prepared foods that can be warmed or are easily accessible when the aide is not present). The planning of menus which lend themselves to such a schedule, meet nutritional requirements, are attractive, and are in the recipient's normal nutritional pattern (as far as this is a healthy one) are important areas in the training program.

Policy with respect to protection of the homemaker/home health aide, is that "unusual" requests may not be made without professional concurrence; for example, preparation of special meals for groups of people not included in the plan. However, occasional "parties" are usually considered an important therapeutic aspect of food preparation. One homemaker/home health aide adopted the practice of casually collecting the somewhat alcoholic spouse of a patient at the corner bar with the promise that his other addiction, home-baked apple pie, would be provided. He got his pie each time and gave up the corner bar (at least on her "days"). The common problem of "awkward" requests is also usually taken care of in agency policy; i.e., requests for food which may not be included in a prescribed special diet or, more sensitive, requests for alcoholic beverages by those who may have drinking problems. By policy, these requests are rarely denied by the homemaker/home health aide; she refers them to the professional staff for discussion with the family. The plan with respect to food problems as with most other problems is a professional responsibility; and changes are made by the responsible professional. The importance of establishing the homemaker/home health aide in the household as a help, and not an inquisitor, mentor, or "manager" in the pejorative sense, is always reinforced in policy, training, and supervision.

Although selection and training may minimize the possibility, policy also establishes the requirement that the homemaker/home health aide may not inflict her own prejudices, minor food fads or nutritional opinions upon the family. The "normal" nutritional pattern prevails, with professionally established (and accepted) adjustments. Aides who have strong objections to the purchase and/or serving of alcohol may decline assignments to families where use of alcohol is normal and not a problem—as they may decline other situations which are uniquely and personally unacceptable.

Special diets may, by policy, be a normal service within the competence of all homemaker/home health aides; or these may be assigned only to selected aides. It is usual in agency policy to

indicate whether or not such services are provided; in any case, policy will also prohibit the preparation of special diets without medical orders.

SPECIAL SERVICES

Special services cover a broad range of activities which may or may not be acceptable. "Acceptability" is usually related to a realistic estimate of staff capability (although it may also drift into the area of vague apprehensions and fears).

Handling Money

The first of these—and it may initially cause discomfort—is the question of the handling of money by homemaker/home health aides. Aides need money to purchase food and household supplies; to purchase clothing and other more costly items of household equipment on behalf of the recipient; to pay bills (many users of service do not have checking accounts). Aides may also need to cash checks for the homebound patient; or collect payment or fees for the service itself.

Agencies vary considerably in their policies with respect to handling of money. Those agencies which require that a "responsible person" be available as a prerequisite for service may prohibit the handling of money by the homemaker/home health aide, except in the case of minor errands (food shopping, payment for prescriptions, etc.). They sometimes do allow the collection of fees for service by the homemaker/home health aide.

Other agencies allow the handling of money if it is directly related to the home care plan (food shopping, errands, clothing or household supplies). They do not allow payment of bills on behalf of the recipient or cashing of checks; they may also prohibit the collection of fees. Agencies support the latter prohibition on the basis of a justifiable unwillingness to allow the aide to be cast in the role of creditor on behalf of the agency. What may begin as a messenger service for the transfer of funds between family and agency may engender an undesirable and inappropriate relationship in which tension focuses around financial problems which the aide is not equipped to handle. Agencies in which aides are involved in a teaching role may, on the other hand, stress money management, and may provide the necessary training to support considerable involvement of the aide in family finances.

Agencies which serve homebound, isolated, or otherwise limited individuals, when availability of a "responsible person" is not required, must face the reality that very little of the contemplated

service will be possible unless homemaker/home health aides are allowed to handle money on behalf of the individual. Policy with respect to the handling of money can be most effective if there is a practical approach to the following:

1 The *need* for such services, given the type of in-home plans which are contemplated.
2 Specific *regulations*, clearly taught and carefully reinforced, concerning those instances in which the aide may handle money (i.e., food purchases only; other purchases—clothing, linens, etc.; payment of bills; check cashing; fee collection).
3 Routine *procedures* which protect the homemaker/home health aide and the recipient in situations where money is to be handled. (Written receipts countersigned by the recipient; separate coin purses for money used in food shopping; routines for presenting sales tags; provision for identification cards and written authorizations for major transactions, such as payment of bills, check cashing, etc.).
4 *Training* of homemaker/home health aides which thoroughly explores problems, not only of money management but of areas of individual sensitivity (both for aide and family) in order to assure a comfortable, detached, yet sympathetic attitude toward the handling of money and any misunderstanding which may arise.

"Attending" the Recipient of Service

The degree to which homemaker/home health aides are permitted to accompany the recipient of service outside the home has varied considerably. In child care situations, where the aide supplements or replaces a parent, she is usually expected to do whatever the parent might do. This may include accompanying young children to school, to medical or other appointments, and on shopping and various recreational expeditions. Adult programs may limit such services.

Factors which affect policy may be: 1) Concern for the physical safety of the recipient and/or unwillingness on the part of the agency to accept responsibility; 2) difficulties in availability of transportation facilities (either common carrier, funds for taxi services, or provision for automobile transportation by the aides); and 3) availability of homemaker/home health aide time for extended services.

In the absence of other resources for "attending," sharp limitation of this service may affect the quality and total success of the home care plan. Many agencies do permit the homemaker/home health aide to accompany individuals on short excursions (to outside garden, on short walks), as a part of the therapeutic

plan to achieve or maintain maximum function. Limitations on service beyond this may mean that accompanied shopping expeditions, which also serve a therapeutic purpose, will not be possible; and that visits to physician's office or clinic may restrict the provision of adequate health care.

Policy which provides for a full range of "attending" services may be established with protective regulations of the following type:

1 "Attending" may be undertaken on the basis of physician's approval combined with agency evaluation of the individual's physical state. Expeditions may be limited in time and distance. Attending may be affected by environmental obstacles (stairs, stopping points along the way).
2 Availability of homemaker/home health aide training in techniques of physical management (stairs, in and out of automobiles, busses).
3 Availability of funds for special transportation services when necessary.
4 Availability of skilled homemaker/home health aides where transportation is to be provided.
5 Attention to community practices with respect to reasonable appointment systems in the various social and health facilities.

DIRECT SERVICES—*Nursing Care*

Because home nursing services have been an esablished part of our health care pattern for so long, they are usually understood. They include evaluation of patient status, the development of treatment plans outlined by the physician, and the provision of direct and supervisory services in accordance with that plan.

A home care plan involving nursing services does occasionally present problems which may not be commonly encountered in traditional home nursing services. Agency policy with respect to the care of the massively handicapped or totally bedfast patient may limit the kind and extent of nursing services that can be provided. The patient sent home following an incapacitating stroke may, even with the presence of a family member and a homemaker/home health aide in the home, require daily or twice daily nursing visits. Home maintenance may be considered feasible and, even from the patient's point of view, desirable if nursing service is provided.

Limitations in agency capability may be such that this service must, by policy, be denied. Agencies which do not allow homemaker/home health aides to administer medication (and many

of them do not) have the policy choice of offering daily or even more frequent nursing visits for this purpose. Where there is no other resource, they may redefine policy with respect to what is permissible for the homemaker/home health aide; or they may refuse to provide services in what might otherwise be a feasible plan. The administration of insulin in situations where the patient cannot assume this responsibility is a case in point, as are the applications of frequent dressings, or treatment which requires unusual investment of nursing time. In some areas, the drawing of blood samples from a house-bound patient, where other resources are not available, might also necessitate policy decisions.

Policy with respect to those direct services, which may be provided in the home by the licensed vocational nurse, may require specific definition and consequently considerable interpretation. In general, the extent of nursing services which are well defined in nursing education and established nursing standards will have less to do with the capability of the nurse than with the nursing time available to the agency.

Social Service

Social services, like nursing services, are governed by established standards. Professional social workers are able to evaluate the social situation of recipients and their interpersonal relationships, and to assess fears and apprehensions which may impede effective use of services. Medical social workers are, by training and experience, oriented to health care, and are aware of the psycho-social effects of illness, the psychic effects of specific diagnoses, and the patterns of response to illness which tend to develop and can affect treatment plans. Familiarity with the health and welfare resources of the community, and the use and coordination of those resources that will enhance health and security, are established as appropriate social work responsibility.

Treatment, or direct service, involves the use of casework skills which increase the recipient's understanding, enhance personal security, strengthen positive interpersonal relationships, and enable the recipient and his family to use services constructively. The effective involvement of the homemaker/home health aide in this process is based primarily upon the development in the aide of an understanding of her own personality, the various ways in which people may respond to the provision of her services, and the effect of her behavior and attitude on these responses.

In homemaker/home health aide services, evaluation, the use of community resources on behalf of the recipient, and the development and support of the homemaker/home health aide are provided as a general policy. The treatment plan will invariably in-

clude those elements that are related to the psycho-social aspects of each situation.

The provision of direct, or "intensive," casework treatment will depend upon the availability of social work staff qualified to provide such services, and upon the availability of social work staff time.

Homemaker/home health aide agencies which focus primarily on problem families may, by policy, offer "intensive social services," either as a function of the social worker assigned to homemaker/home health aide services or of the family worker. When casework services are more appropriate for other community agencies (i.e., health, rehabilitation, or mental health), they are referred; the home care plan is then coordinated with these services.

The health care agency which has a limited social work staff may, by policy, limit its services to evaluation; to the adaptation of home care plans to individual psycho-social need; to coordination of needed resources; and to supervision and general support. Health care agencies frequently make maximum use of the social worker as a consultant.

In homemaker/home health aide services provided in public welfare departments, the "intensive" aspect of social services may, by policy, be assigned to the worker directly involved in the home care plan; or it may be the responsibility of a worker responsible for other services to the family. In such instances, the social worker assigned to the homemaker/home health aide service may provide diagnostic consultation and/or supportive or supervisory services to the homemaker/home health aide which, as in nursing care, are directed to implementation of the home care plan as it relates to acceptance, maturation and personal functioning and increasing understanding and skill.

Policy decisions concerning the extent to which needed on-going casework services can be made available are therefore affected by availability of staff time and capability of staff. Many agencies make the decision that direct services (i.e., intensive as opposed to supportive) will be provided to the extent that they ensure the success of the home care plan. The objective is to help the recipient and/or family to use the combined in-home services effectively and to develop a positive approach to improved function; or to move toward acceptance of more intensive therapeutic services elsewhere in the community when necessary. Other agencies make the decision on the basis of selection. Given a number of families in need, the services needed by *all* families will have priority, and a smaller *selected* group will be offered intensive service confined to a flexible but defined percentage of total working time. Agen-

cies which "assign" casework responsibility to social service staff will not see effective results unless the staffing pattern is one which allows sufficient time for this purpose.

Physical Therapy, Occupational Therapy and Speech Therapy

Policy defining the provision of these therapies may be restricted to evaluation or diagnostic services, may provide for the establishment of a therapy program to be carried out by others (family members, the nurse or the homemaker/home health aide) under the therapist's supervision, or may offer regular treatment by the therapist in the patient's home. Again, policy will be determined by agency capability. Agencies which purchase such services from outside sources on behalf of clients will be less apt to encounter difficulty if there is understanding of the specific services required. These will depend upon the type of patient to be provided services: mildly handicapped persons with optimum results anticipated; patients with major problems for whom the objective is to restore enough function to make home care feasible; patients following an established rehabilitation program; or patients who are to be treated on the basis of need whatever the situation may be.

Nutrition Services

Policy with respect to nutrition services may limit these to general education of agency staff, emphasizing training of homemaker/home health aides in order to increase knowledge of essential nutritional needs; may provide for consultation to staff members in individual case problems (special diets, individuals with serious nutritional problems); or may extend to direct service to families in sporadic or regular home visits.

REGULATIONS WHICH SAFEGUARD THE PROVISION OF EFFECTIVE SERVICES

"Regulations" have been mentioned as related to certain specific aspects of agency policy. Although in some instances certain "rules and regulations" may have general application, there is usually a set of policy "regulations" which apply most specifically to the homemaker/home health aide in her work, and which are intended to sharply define certain desirable and undesirable practices. Usually they are incorporated in a homemaker/home health aide handbook, which is used in orientation and reinforced in training and in conferences. In general, regulations include the following:

1 *Confidentiality* is stressed in various ways throughout training. "Regulations" require that names never be mentioned in conversation except with the professional staff, and that identifiable information never be discussed outside the homemaker/home health aide supervisory relationship. Emphasis is placed on avoiding the tendency to "chat" or "gossip" in the homes of clients about other recipients of service.

2 *Assignments and duties* must be limited to those included in the home care plan. Changes may not be initiated by either the homemaker/home health aide or family without professional approval. The basis for this is apparent. In addition to reinforcing the understanding that professional judgment must be the basis for all aspects of the plan, this relieves the aide of responsibility for refusing to perform certain extra or exceptional tasks in those situations where refusal might affect the development of a positive relationship. Where the "rule" is that *no* change is possible, there can be no gradual drifting into unprofessional and perhaps undesirable services and attitudes.

3 *Schedule*, i.e., days of the week and hours of the day, must be adhered to exactly as outlined in the plan. Changes—even minor—may not be initiated by either the homemaker/home health aide or family without prior professional approval. This does not mean that changes for the sake of convenience may not be made. Such changes may not, however, be initiated unless the schedule change has been approved. The tendency to shift hours and days as a "private" arrangement ultimately makes for a situation in which "favors" given or received may affect the relationship of the homemaker/home health aide and the family. It is also one which may cause considerable administrative confusion.

4 *Advice—giving and getting*—concerns the prohibition against sharing personal or health problems, offering advice (unless as a part of the plan), questioning aspects of the plan, or implying that other alternatives may be desirable.

5 *Medical problems and medical care*—Homemaker/home health aides are expected to encourage adherence to medical prescriptions and to avoid discussion of diagnosis. They must avoid opinions concerning desirable or undesirable medical care or treatment methods.

6) *Other acceptable and unacceptable practices in the home:*

a) *Meals*—most agencies establish a policy concerning the taking of meals in the home. In child care, the homemaker/home health aide may have meals with the family, particularly if the mother is absent (although some agencies do not allow this). Agencies providing services to adults usually

establish a policy that meals may not be taken in the home; or at least that the aide must provide her own food. *Smoking* during the assignment is also usually forbidden, as is watching television (a practice which housekeepers sometimes follow as they work).

b) *Arguments*—a flat prohibition against any expression of anger, no matter what the provocation (and it is recognized that it may be great in some instances) is usually accompanied by assurance that feelings may be freely ventilated with the professional staff and, more important, by a policy that the homemaker/home health aide may ask to be relieved of assignments that are essentially inimical to her without prejudice. (Recipients may request changes on this same basis.) It is accepted, in other words, that there are occasionally situations which may be personally intolerable. Such a policy is very effective, and seems to increase the homemaker/home health aide's willingness to sustain difficult experiences rather than the reverse.

7 *Gifts and personal involvement*—Most agencies prohibit the giving and taking of gifts, money, used clothing, or other such tangible exchanges. Personal involvement beyond what might be considered genuine, but professional, friendliness and concern is discouraged, with great emphasis placed upon communicating the interest and concern of *all* agency personnel rather than the "specialness" of any single individual.

8 *Complaints and grievances about the agency or its assignments*—Homemaker/home health aides may not share complaints about the agency or the assignments with recipients of service. When there are occasional requests that the aide meet emergencies, unusual assignments, days on which pressures are great, when comment at a recent conference has been critical, the homemaker/home health aide may feel a strong temptation to express her depression or her grievance in a household where she believes she will be heard sympathetically. Training emphasizes the importance of maintaining a serene attitude in the household. Ample opportunity for the expression of such reactions is allowed in frequent conferences; the use of the recipient of service as a support is a reversal of roles which is not permitted.

RECOMMENDED SERVICE POLICY

The most desirable service policies are those which include the broadest section of the community. A homemaker/home health

aide agency which serves families with children as well as the disabled or chronically ill adult, which supports families whose need is psychological as well as those whose need is related to health problems, will obviously meet the needs of the community most effectively. Similarly, agencies which will provide services to those in a wide range of economic and cultural circumstances will become a firm community resource. These are the agencies which: 1) provide both short and long term care; 2) will adapt to meet the needs ranging from hourly to full time care when this is appropriate; 3) do not adhere rigidly to the once or twice weekly assignment; and 4) can provide for daily need. Such agencies will certainly fulfill the principles of homemaker/home health aide service as they affect protection of family integrity and avoidance of unnecessary institutionalization.

Broadly based programs which include an interdisciplinary approach to evaluation, planning and service, and which will accept as genuine, needs ranging from supportive to therapeutic treatment, will unify the home care resources of the community, acting as a strong defense against duplication, fragmentation, confusion, proliferation of community resources, and the inevitable chasms—so frequently referred to as "gaps"—in service, into which the defenseless fall. Such agencies will be most effective when both the professional and non-professional staff are well qualified by training, and when established intra-agency procedure and policies are clearly stated, understood, and accurately implemented.

When such a sensible and ultimately practical approach is not possible because of limitations in community understanding, or community funding priorities which reduce the status of homemaker/home health aide service, the intention in policy to achieve such quality objectives as far as possible will do much to increase community understanding. Where services fall short because of inadequate support, the shortcomings are best understood if they are not rationalized, but are clearly defined in terms of the difference between a less adequate present possibility and a potentially high quality community resource.

CHAPTER 5

Determining Need

The determination that there is a need for homemaker/home health aide services in the community will be affected by the community perception that such need exists. By objective observations, the major areas of need are established, based upon repeated evidence that services in the home could be appropriate for selected groups in the population, or for significant numbers of all segments of the population. Surveys may be helpful; but they may be unreliable as real evidence of need—as are isolated examples of need. Services which are developed primarily because funds are available, or as an inappropriate but "more economical" resource, may in the long run defeat the purposes of sound planning. Need, as a basis for the development of a homemaker/home health aide program as a new service in the community, is best established when there is evidence that a significant number of families and/or individuals are present in the community for whom the place where the most effective care can be provided would be the home.

EXPRESSION OF NEED FOR NEW SERVICE

Most new services begin because, somewhere in the community, someone begins to feel the pressure of unmet need. This may be a sporadic need expressed in various parts of the community, or it may appear as a result of steadily mounting pressure which is widely expressed. Usually such pressures are felt first in those "helping" services which already exist in the community: public and/or private social agencies, public assistance programs, family service agencies, child care, mental health services, or health services (public health departments, hospitals and clinics). Less often, the expression of need may come first from the "private sector" of the community: private groups or individuals who believe that an important resource is lacking.

"Sporadic" need is felt when an occasional crisis occurs for which no solution appears to be available. The need for homemaker/home health aide services may become apparent when one or both parents in a family in which there are minor children are

suddenly unavailable to provide normal care and supervision; when a family is faced with the disability of one of its members and there is no resource for home care for the disabled member; or when the slow debility of an older person reaches a point where some supportive care is necessary, and appropriate care outside an institution cannot be found. These may appear as isolated problems which are recognized and cause a stirring of interest. When they have been dealt with however, they may reinforce the impression that the community needs services that are not available.

Patterns of Community Response to Need

Characteristically, communities are slow to respond to occasional expressions of need by providing new structures with which to meet them. Where there is such response, the stimulus to action may be the example of a neighboring community which has established a successful service. Groups of individuals in clubs, fraternal organizations or charitable groups may decide that a pressing community need will be their focus of activity. In community organization, as in other aspects of life, increased emphasis on a currently fashionable effort may develop; this may be followed by the desire to engage in a new activity which will demonstrate that the community is participating in a widely expressed new interest. Community development, which is initiated in advance of generally determined community need, may prove successful in uncovering previously unknown problems, provided a need really does exist and the services which are organized are related to that need. Failures occur where there is insufficient exploration of the need and unrealistic planning.

In the development of a new homemaker/home health aide service, the community which decides it would be interested in providing child care services on the basis of full family reimbursement—when the need is for fully funded services for low income groups—may expend a great deal of effort in developing services that cannot be used. The result is a false demonstration to the community that "there is no need" for a homemaker/home health aide program. A community that is predominantly made up of young families with school age children may develop services for older persons because funding exists, or because there has been a wide general interest in services for the aged. Lack of demand may retard development of realistically focused services which *are* needed.

Probable Causes of Program Failure

Services may often be developed initially as supplemental resources to be used in the occasional situation where special need

arises. They may grow slowly, demonstrating their own usefulness and expanding into broader areas of need as such needs arise. There have been failures in homemaker/home health aide programs which have occurred when the relationship between need, planning and funding is not clearly understood—but this is not to say that such efforts are invariably failures.

When new services are developed and are not used, lack of response is attributed to a variety of causes, the most frequent being "lack of interpretation to the community." It could be stated as a general maxim that any community service in need of a public relations program to keep it going is questionable in some aspect of its essential planning and/or organizational structure. It is probably focused on a population that does not exist, or if it does exist, must overcome impossible barriers which stand in the way of utilization (eligibility, funding, conditions of service, or range of services provided).

Programs which are organized to meet only a small segment of a large need may suffer from a false kind of self-congratulation. Child care services provided on the basis of full reimbursement to upper- and middle-class families, when the greatest pressure exists in slum areas where there are no services at all, may be fully utilized at one end of the community while growing need continues to create misery at the other end. Services provided on an acute-care or short-term basis, when the major pressure is for chronic care on a long-term basis, may also seem to be solving community problems. Solutions to real community problems in such instances usually exist in brochures and leaflets rather than in reality.

Objective Evidence of Community Need

Evidence of real community need for homemaker/home health aide services can usually be gathered from public and private "helping" agencies and from other sources in the community where there is objective evidence that there are situations in which homemaker/home health aide services could offer members of the community an appropriate resource. For example:

1 The consistent overcrowding of child care institutions or out-of-home placement resources with children for whom institutional care or placement are inappropriate;
2 The overutilization of acute care beds by older persons who are not acutely ill;
3 The use of boarding homes or nursing homes for persons who could remain in their own homes, and would prefer to do so.
4 Repetitive evidence that family units are breaking down because of the unremitting pressures of caring for physically or mentally disabled family members; and

5 The inappropriate use of institutional facilities, i.e., placement of mentally retarded or physically handicapped children in adult senile facilities, or placement of mentally normal physically handicapped persons in institutions for the mentally ill or mentally retarded.

Repeated occurrences of such evidence of need may be expressed first as agency problems which require an inordinate amount of staff time in the search for solutions. They may develop a general recognition that there is overcrowding of existing facilities with inappropriate placements. They may result in efforts to meet the situation inappropriately, by providing additional acute beds for chronically ill patients, adding new adult beds to be used for the inappropriate placement of children and handicapped young adults, or seeking more foster homes for children and/or adults who might well be cared for in their own homes. Community awareness of such situations frequently provides the motivating energy for the development of homemaker/home health aide services and, when they have appeared persistently rather than as occasional problems, the services which are developed represent valid community response.

External events may occur which also affect community structures. In the development of homemaker/home health aide services, the sequence of national and state legislative changes began with public assistance provision for homemaker service in public welfare departments on a cost sharing basis; the provision of Medical Assistance to the Aged which provided for grant allowances in the recipient's budget for the purchase of homemaker service, and the enactment of Titles XVIII and XIX of the Social Security Act providing for home health aide services, are examples of such external events. Legislation does not in itself produce new community structures, although it may act as a strong stimulus since it provides, in part, a solution to the key issue of funding. Legislative mandates which require the development of homemaker/home health aide services to meet the needs of selected groups may act as a further stimulus. The way in which the community moves to meet *total* community need, using these as well as other resources, will depend to a large extent upon its own capacity to evaluate, plan and implement services.

EVALUATING THE NEED

Although a number of examples have been given which might act as indicators that homemaker/home health aide services

should be organized, these may not invariably present the community with a clear picture when it comes to the point of action. Small communities may see the outlines of the problem more clearly than large urban centers with their multiple agencies and multiple problems. Evaluation of need (as well as the development of structures to meet it) may be complicated in the case of rural areas where distance and scattered population create difficulties.

Agency staffs tend, naturally, to see their own problems as paramount for the community. The needs of children in Aid to Families with Dependent Children households are important to these case workers or to the Child Welfare Services case workers. Those of the mentally retarded or the mentally disturbed are most important to the mental health worker. The chronically ill are most important to the institutional health worker; and the needs of the "private sector" are important to the family service agency, the private physician or community groups and voluntary agencies with special interests. In general, workers in the field appropriately tend to focus on the needs of those they serve.

It is sometimes difficult to achieve a broad and generous interest in total community need. As one worker aptly put it, "I represent a vested interest. In fact I'm paid to represent that interest. When I've ensured services for my own clients I'm willing to consider other needs." This happened to be expressed during a discussion of a proposed homemaker/home health aide service for a group of specifically handicapped children which was numerically small within that particular community. This tendency is best offset when the necessary balance is achieved in a community or areawide planning approach which is comprehensive in orientation: that is, when total community need is evaluated, and priorities set in those areas for which there is no systematic resource and which present the greatest threat to the health and welfare of the whole community.

Communities which have a common council for the exchange of information and for the discussion of community or areawide problems are in a good position to assess the extent of these problems provided there is full participation by all sections of the community and the participation is informed rather than routine. Here, too, vested interests may exert pressure. The most influential participants in such a group may not invariably represent the area of greatest need. Whether or not there is such a common forum with full or partial participation, those who are considering planning and/or leadership in the development of homemaker/home health aide services must inevitably consider a number of questions. These must be related to the specific purposes and objectives of such services.

Here it may be appropriate to quote some discussion from agency staff workers.

> "If . . . I could call on someone I could trust to take over for anywhere from a day to a couple of weeks on a 24-hour basis while I work out a decent plan for some of the children, of course there's a need. *It doesn't happen every day* but when it does I'm really pushed and so are all the other workers. If you're talking about regular after-school supervision for a few hours every day *there are a good many more kids* who could use the service. If you're talking about *a few hours a week, we couldn't use the service much.*"

Or:

> "Our biggest need is for long term help for some of our older people. Sometimes it might be full time but not often. We could use *part-time services in almost unlimited amounts.* But it would have to be someone we could get right away, who'd stay and who'd get along. And unless we could get medical care at home and health supervision tied in it would be a risk."

Or:

> "We have a *limited* but very real need for services to patients who could be discharged home from the hospital safely a few days earlier. This would be possible if there were someone to see them safely through the convalescent period. We would, of course, assume responsibility for medical follow up."

Or:

> "We need *a small group,* probably two or three or at most five people who could be carefully trained to be with massively handicapped children and adults. Usually they have families or they wouldn't be at home at all. But we would want them for full days on the days they do come. We would want to give family members a total break. A few hours each day wouldn't help us much."

These discussions indicate, in a general way, what might be considered the *areas* of need. We hear that *volume* services are needed on a *long-term part-time* basis for older persons and for school age children. They are needed for a *smaller number* on a *full-time* basis, and for a *still smaller number* on a *full day intermittent basis.*

The question of whether a community needs homemaker/home

health aide services may evoke either a negative or an affirmative response—but in either case it is an unreliable response unless there is an effort to get at specific need. In seeking to determine need, and whether or not the community has the potential resources to meet it immediately, an approach which presents the broadest and most flexible possibilities of the service will produce the clearest picture of the need where it really exists, and thus establish a framework in which long range as well as immediate service objectives might be set.

EVALUATING SPECIFIC AREAS OF NEED

Type and Volume of Services

Given this broad framework, evaluation of need might be directed to specific areas. If there *appears* to be a need, in what sections of the population and under what circumstances does it occur *most frequently* with respect to:

1 Age groups: families with children, young adults, the middle aged, and the aged.
2 Major presenting problems: family crisis, acute illness, chronic illness, physical handicaps, emotional disability, or retardation.
3 Range of services required: personal care, health supervision, nutrition, environmental management, educational services in child care practices, healthy living standards, and physical rehabilitation.
4 Economic status: recipients of public assistance, marginal groups on pensions or in partial employment, and individuals capable of purchasing services if available. This last group can usually not be discovered through community social agencies. Hospitals, health departments, group health or medical organizations can sometimes respond to questions as to whether such services might have high priority in their estimation or experience.
5 Extent of services required: full time, part time, part time intermittent, short term, or long term.

Given the fact that *most frequently* can be considered a somewhat elastic formulation, some knowledge of the source of the response may be important. In an agency having contact with approximately 100 families in the course of a year, how frequently might the service have been required? In an agency, which in large urban communities may have contact with many times that number, responses concerning frequency may be less specific, but may at the same time present a picture of almost unremitting pressures in some sections of the population.

Before services are actually available, it may be difficult to obtain even a reasonably accurate picture of the number of persons in need. Very few agencies keep records which specify—at the time of its occurrence—a request for a service not yet available. The reports of both agency staffs and of community groups and individuals can only be evaluated in terms of the estimated volume of their contacts with those they report as having needed, or presently or potentially need their services.

Determining Need Through Surveys

The methods by which such information is obtained frequently include surveys or special studies. Community organizers often propose such surveys of unmet need as the best way to obtain accurate information. Information is usually considered "accurate" when the questions are invariable and the responses can be formulated statistically. The best surveys are those that can be conducted over a projected period of time with a projected caseload. Surveys which attempt to gather information about past occurrences from data that have not been invariably recorded may be based upon impressions. They may be combined with a knowledge of the size and characteristics of the agency or group experience from which the recollected estimates are drawn, but such recollected experience is not very reliable.

It may be just as accurate to disregard the survey method entirely, relying upon interviews and discussions with those who are experienced in related services and knowledgeable about community needs. Surveys based upon projected time periods—using new cases in need coming to the attention of the respondent to a questionnaire—must take into account the necessity for a general and invariable commitment to recording, a clear understanding of the projected services, and the pressures of commitment to ongoing responsibilities. The latter tends to discourage accurate and invariable recording of requests for a service not yet available and therefore is not helpful in solving the immediate problem.

One community conducted a series of surveys over a period of several years in order to demonstrate the need for homemaker/home health aide services. The last survey indicated 250 families in need. The program, when it was organized to provide such services, received almost 750 applications for service by the end of its first six months. A better indicator was found in two surveys of physicians in the community. These asked only for a priority ranking of unmet needs in the community. Homemaker/home health aide services were ranked first in one survey and second in the other. An adjacent community, which used the survey method and estimated need in approximately 500 families, was

forced to close its homemaker/home health aide agency because of lack of utilization of the service. This was mainly because it had been estimated that the majority of the families could pay in full; the need existed primarily in the low income section of the population.

Whether or not the survey method is used, the results of the evaluation of need must always consider that the *availability* of services is the best case finder. Cases follow services if the services are rationally planned. The *nature* of the need may be accurately described by those who have most often attempted to find alternatives to the service in the past.

Determining Need by Available Funds

One of the poorer reasons for "evaluating the need" for service is that there are funds available to provide specific services. Usually this need is sketchily demonstrated to meet the requirements of the funding source. An example of this might be short-term grants from special interest groups with requirements geared to that group. Grants from public sources for development of a service without community plans for service continuation are another example.

Immediately following legislative authorization of home health services as a part of Medicare and Medicaid, some communities organized homemaker/home health aide training programs and developed new agencies. This was done with the expectation that home health service programs would be financed entirely by the government insurance program.

The intent of the legislation was to provide for specific benefits in selected situations; it added the home health service benefit in order to provide a range of treatment alternatives for beneficiaries of the insurance program. While this legislation acted as an important stimulus to the development of in-home services, Medicare and Medicaid could not realistically become a total funding resource; and new services could not be planned or delivered in patterns which met real community need. Such planning tends to discourage more positive and more flexible future effort. It also tends to artificially limit and distort services to individuals whose real need cannot be met by services which are focused on a single group under specified conditions that are not intended to meet total need.

A more valid approach is to attempt to coordinate a variety of available funding sources, using established mechanisms such as insurance or grants as supplements to basic community funding, or as a part of a phased effort projecting a future broadening of the financial base and, consequently, of services. Implicit in the

word "coordinating" funding sources is the idea that contributors will not so restrict services as to make them inappropriate to meet real community need.

Other Community Considerations

Evaluation of need may be viewed in the light of community considerations other than those outlined above:

1 Is there a section of the community population that is at high risk?
2 Are there disproportionately large numbers of aging persons without supportive services of any kind available to them?
3 Are there large numbers of children in single parent families combined with an absence of child-care facilities?
4 Are short-term convalescent facilities or foster home placements lacking?

When such considerations are presented as demonstrating need for the development of homemaker/home health aide services, they may be balanced against the total community need and the long-term plans for comprehensive community services. Will homemaker/home health aide services be an appropriate resource to meet these needs, or are they only *one* of an array of services that will be necessary? Are the pressures for the services based upon inappropriate placement or use of existing services? Is this based on a desire to avoid the development of other resources which may appear to be more costly although clearly more appropriate?

Those who develop new services and who promise magical results fail when attempts are made to distort services to meet needs for which they were never intended. Homemaker/home health aide services do, as a matter of fact, often deliver magical results, but only when they are needed, well organized and appropriately used.

CHAPTER 6

Organization and Administration

Every program hopes to provide its services effectively, establishing a structure so that all activities are geared to the central purpose: the delivery of quality services with the minimum investment of time, effort and money.

Effective services rely on an organized effort in which responsible direction is established, and policy implementation is assured. Quality is supported by means of adequate staffing, established functional responsibilities and sound personnel practices; and efficiency is assured by defined procedures closely related to service needs. Economy is guaranteed by means of established methods of budgeting, cost analysis and policy with respect to fees and income; and program growth and change are achieved as a result of systematic evaluation methods.

Like all programs, homemaker/home health aide services are unique in certain ways. Special characteristics distinguish these services from other programs and require differences in administrative emphasis and approach.

These special characteristics are not all invariably present in every program; certain of them do, however, appear frequently. They may be summarized as follows:

1 Homemaker/home health aide services may be placed in various settings; "parent" agencies may have a variety of differing functions of which the homemaker/home health aide program may be considered an "adjunct."
2 The services almost invariably demand an interdisciplinary professional approach with certain of the disciplines drawn from sources outside the agency. The functions of the various disciplines are multiple in purpose, combining direct service to recipients, supervision of the homemaker/home health aide, training and joint responsibility for evaluation, planning and implementation of the home care plan.
3 The interdisciplinary relationships require special procedures to ensure effective cooperative function. Dual, or multiple supervision of the various aspects of homemaker/home health aide activity must be understood and structured.
4 Scheduling of homemaker/home health aide time in the home, in programs which offer part-time services, may create prob-

lems unless these are anticipated and planned for. The provision of services on the basis of need—in a context in which the meaning of "need" may be open ended and variable—presents problems in budgeting and staffing.

5 The employment of non-professional personnel requires an approach to personnel practices which is frequently misunderstood in the community. The problems of budgeting in a service which is frequently without a reliable and continuous financial base may exert pressure to adapt policy and personnel practices with a resulting sacrifice of quality.

PROGRAM DIRECTION AND DECISION MAKING

Homemaker/home health aide services of good quality have been provided in family service agencies, visiting nurse associations, public welfare departments, in the home health programs of public health departments, in organized home care programs, and in independent community agencies developed specifically to provide these services to individuals and/or under contract or agreement with other community agencies. The choice of setting, although it has been the occasion for considerable discussion, has had less to do with quality of service than the presence or absence of those elements in the program essential to the provision of good service.

The development of consistent services and sound methods of delivery depends to a large extent upon the knowledge and judgement of a *designated program administrator*. This does not mean that boards of directors, advisory committees, the administrative staff of a parent agency and of the service itself do not have a participatory responsibility; it does mean, however, that authority and responsibility for the services will rest finally with a single individual. This may be a designated supervisor or staff member in a multiple service agency, or it may be the executive director of a free standing agency. The essential consideration is that the direction of the program is in the hands of an individual who has administrative capability, is familiar with the goals and purposes of the services, and is free to become intimately involved in all aspects of their delivery.

The principle of such vested authority is best understood in terms of the characteristics of the services. They are provided primarily by non-professional personnel in a setting (the home) which is remote from the agency authorizing them. The assessment of the relationship of individual or community need to established policy is frequently difficult; the reconciliation of differing professional and agency objectives as they bear upon the delivery of service is equally difficult.

Understanding can best be gained by an individual who is in close daily contact with the service. For him, the problems are practical rather than theoretical, and he can respond to a crisis or to the need for flexible policy exceptions or broad policy change on the basis of personal knowledge. Delegating a staff member to "oversee" the service without delegating to him considerable responsibility and the authority to make immediate decisions when necessary or to project necessary planned change will usually result in a vague, poorly understood and, at times even dangerous set of services.

The result may be a gradual drift away from those functions which have been defined as "safe" for the homemaker/home health aide. There may be acceptance or rejection of applicants whose needs are either too routine or so complex that the risks in providing services would be great. Charges for services may become arbitrary. Service plans may be altered without the participation of those best equipped to evaluate change. Training standards may be relaxed because of service pressures. Homemaker/home health aides may lose their identification with agency goals and adopt attitudes that do not further the objectives of good care. Records may assume characteristics which are personal to those who keep them and are unsuitable for objective assessment. Scheduling of homemaker/home health aide time may assume bizarre and expensive patterns. This can convey to those outside the program an erroneous image of the service.

The maintenance of a consistent service is rarely possible when it is the responsibility of a group, a committee, or an executive who is remote and who carries other and, in his view perhaps, more pressing responsibilities. For these same reasons, the administrator of a homemaker/home health aide service will preferably carry this as his only responsibility. Very small program units may necessarily be assigned as a part-time administrative responsibility. When this is the case, it is still desirable that a single individual assume responsibility for "the program," as differentiated from supervisory or direct service—though all three may occasionally be combined in the same individual.

Administrative quality is most often found in individuals whose interest is in providing a setting in which the needs of present and potential recipients of the services are primary. Those who have a relatively greater interest in meeting the expectations of boards of directors or of community authorities, or who accept too literally the present limitations of the agency, do not usually possess the leadership qualities that are important for creative program development.

POLICY IMPLEMENTATION

However policy has been established—and this is usually based upon perception of community need and estimated agency capability—the administrator must be accountable for the general maintenance of such policy; for decisions involving borderline situations or exceptions; and for response to factors which prevent its implementation. Decisions concerning the need for policy changes and the effect of such change upon the community and upon the service, and projected procedural and staffing change as a result of policy change, rest finally with the administrator. The capacity to respond with flexibility, imagination, and decisiveness to the policy problems of the agency has a direct relationship to the capacity to grasp the implications of change, their effect upon broadly based long range objectives, and to thorough familiarity with the program as it functions. Breadth of vision is related to a well thought out philosophy about the basic needs of all people, the more particular needs of that section of the community which is being served (or will be or should be served) by the program, and the most desirable and comprehensive community stance for meeting these needs, whether or not this is immediately possible.

Pressures for policy changes as they affect homemaker/home health aide personnel practices frequently arise. Such non-professional personnel may become the expendable section of the staff when hours and working conditions are considered. It may be difficult to interpret the importance of sound practices for what may seem to some a group of domestic day workers. If the administrator is insecure in his understanding of the need to pay adequately for work in which considerable skill and responsibility are demanded, he may find himself administering a program in which those skills are no longer available. Pressures to allow homemaker/home health aides to provide services beyond the scope of their training in order to provide a cheaper service as a replacement of professional services, and pressures to limit homemaker/home health aide practice in order to protect vested professional interests, do occur in communities which have homemaker/home health aide programs.

Familiarity with the program "as it functions" is best achieved through the exercise of considerable imagination and skill. Reports, records, and staff conferences contribute only a part of the necessary intimate knowledge. Community response, expressions which describe the community perceptions of agency policy, add something to this understanding; so does constant attention to and awareness of the staff's own understanding of policy as expressed in characteristic individual policy implementation. The perceptions expressed by homemaker/home health aides, who are

usually the prime carriers of agency attitudes, are particularly important: "We *never* do people's laundry"; "I'm not *supposed* to help you with that. It's against the rules." So, too, are the remarks of the clients: "My homemaker/home health aide says she *can't* wipe up the bathroom floor and I've spilled something on it"; "Why can't she come? I have a cold but I don't think I'm contagious anymore. She says she can't." Very small, all of it. The administrator who is a listener will build considerable intimate knowledge from it.

Policy implementation may, therefore, be assured in a variety of ways. It may be expressed verbally; it may be formulated in written statements or policy manuals; it may be continually assessed through review of records which describe program activities in terms of individual service activities.

Verbal Policy

Small agencies rely on verbal communication and the daily or hourly reinforcement of mutual understanding through constant contact: nurse-social-worker-homemaker/home health aide and allied staff working together in many situations and with ready access to the program administrator are rarely in doubt. Such doubts as do arise can be resolved on the basis of mutual discussion: i.e., "Let's not close any case unless there's a post-service plan. Better put it in the record in writing, too"; "We ought to explain carefully every time we open a case exactly *what* the homemaker/home health aide will do and *when*. In writing, but verbally too. Lots of people forget what they've read."

Informal verbal reinforcement of policy has the advantage of its informality. It has the quality of liveliness which enhances learning. It lends itself well to the kind of repetition so necessary for the non-professional, and is less apt to be ignored. Written materials, unless they are well planned, tend to be viewed mechanically and are more readily ignored. Verbal policy alone, however, has the disadvantage that it lends itself to personal interpretation: the spoken word can vary, and with it the precise ununderstanding of policy and its limits. In a larger agency, the administrative attempt will usually be to provide a structured parallel to informal communication which leads to unanimity of approach.

Written Policy

The two extremes in the development of written policy are familiar. Enormous manuals which are elaborately indexed and often impractical for daily use lie at one end. At the other is a minimally recorded general statement of purpose which can be

variously interpreted. The basic need of all personnel is to have available for ready reference the following information: 1) the purposes and goals of the agency; 2) its clientele; and 3) the services which are provided: those which are available within the agency and those provided through other sources. Information about services should include the pattern of service; the conditions which govern eligibility for service; the conditions which govern the termination of service; and the procedure for the "exceptional" situation in which established policy may be set aside for a single individual or group of individuals.

Such written policy will be most effective if it is used as a basis for staff orientation; if it is reviewed frequently and in the light of daily practice; and, most important, if staff experience is brought to bear upon it so that organized change may occur when policy appears to be ineffective or impractical in any of its aspects.

Records

Service activities as they are described often differ considerably from daily practice; it cannot be assumed that agency policy is being implemented because written policy is frequently referred to. "Review" in terms of policy implementation is a continuous process. It implies frequent administrative attention to practice as it is expressed in recorded activities.

Record keeping is often the most troublesome of all responsibilities for a service oriented staff. For this reason, a clear understanding of the purpose is essential. The individual record becomes a working document in which the staff may see the outlines of a problem and the emergence of their coordinated efforts to deal with that problem.

Records provide a means of coordinating staff activities. Each participant in the plan may see how the components of the plan are meshed through the activities of other participants. Records contain a history which is available for those who may, at a later time, participate in the provision of services. They offer an objective statement which can be assessed. For the administrator, they are the detailed fleshing out of the program. Through records, the appropriateness of service activities to policies and to program goals may be evaluated.

Recorded information will usually include the presenting need, the circumstances which may affect or qualify need, the projected plan, and the specific services which will be brought to bear to meet that need. It narrates the history story of care and measures the effectiveness of the plan. It identifies the circumstances that require modifications in the plan. It offers, in periodic summaries, a picture of the status in relation to the plan, and outlines the

circumstances which bring about a decision to terminate the service.

Although such recorded information can be effective only if it is vivid and provides a living picture of the family, the home and the interaction of all who are concerned in the plan, brevity in recording and the elimination of all "behold me busy" mechanical devices will make record keeping a useful tool rather than a tiresome chore.

The assignment of responsibility for recording is important. Good records are the result of an understanding by each participant in the plan of his specific responsibility for recording and, most important, of his familiarity with the total content of the record. Summary recording is often most effective when it is a joint effort. Although some homemaker/home health aide services assign recording responsibilities to the homemaker/home health aide, this is only effective when it is supplemented by verbal reporting, which is often livelier and far more informative—particularly when homemaker/home health aides find recording difficult.

SERVICE QUALITY

The responsibility of the administrator for the quality of the services is carried out through:

1 The selection and placement of staff prepared by training, temperament, and interest to provide good services.
2 The employment of staff in numbers adequate for supervision, training and direct services.
3 The identification of staff functions and activities appropriate to the various needs of the service.
4 The establishment of procedures that ensure interdisciplinary communication and action.
5 The establishment of procedures that provide for continuing evaluation of services as they are delivered in the home.

Staffing

Homemaker/home health aide programs vary considerably in the range of services offered directly and, consequently, in the kinds of professional staff employed. Initially, programs were placed in public and private social agencies; these agencies usually employed social workers both for direct services and as supervisors of homemaker/home health aides, occasionally drawing upon outside sources for health care, psychiatric consultation, and other needed services.

More recently, the concept of comprehensive in-home services

has stimulated the development of programs which consider an array of professional services essential, either providing for these by employment of all professional skills or integrating the necessary skills through contractual arrangements. The "ideal" homemaker/home health aide service program is now seen as one which ensures availability of medical participation, nursing and social services; many programs have added physical therapy, occupational therapy and speech therapy; nutrition consultation; psychiatric consultation; and participation by home economists. Interest in ancillary services which increase the effectiveness of home care has begun to develop: i.e., meals-on-wheels; transportation; "friendly" visiting; and the use of "community aides."

This array of services—either directly responsible to program administration or involved in care services by contract, agreement or informal acceptance based upon mutual interests and goals—offers a qualitatively broadened service; it also poses problems in coordination and program direction. A guiding principle for the administrator must inevitably be the merging of all skills and services so that they become a unified plan at the point of delivery.

Responsibility for the Care Plan

A basic premise in this coordinated effort must be the placement of administrative responsibility which ensures development, maintenance and termination of the "care plan" within the service agency itself. The "care plan" describes the total effort which is to be made to meet the needs of the individual recipient. It is based upon an assessment of his situation, the establishment of the goals of the services which will be provided, the kind and volume of services which will be provided, and the source of these services either within the program or drawn from sources outside the program.

Although all participants in the care plan necessarily contribute their special skills and planning competence, the coordinating function, decisions which govern those aspects of the plan which are specific to the goals and purposes of the agency, and their essential relationship to the established policies of the service, rest with the service administration. The functional and procedural aspects of the service must therefore be established in order to define and implement this coordinated, goal-centered approach.

Ratio of Professional Staff to Homemaker/Home Health Aides

The ratio of professional staff to homemaker/home health aides may vary depending upon the population served (complex health

problems and groups with multiple psycho-social problems require relatively more intensive professional services); the services regularly available from outside sources; and the training needs and level of competence and judgment achieved by the total group of homemaker/home health aide employees. The ratio of one professional staff member to eight to 13 full-time homemaker/health aides is generally accepted. When the service employs numbers of part-time homemaker/home health aides, this ratio may not be reliable. Whether a homemaker/home health aide works as a full-time or part-time employee, responsibility for her performance will require approximately the same amount of supervisory time. Modification of the ratio of supervisors to homemaker/home health aides is more accurately based upon the *competence* of the homemaker/home health aides than upon the number of hours of employment.

The thinner "spread" requires careful attention to the use of professional time. Priority is assigned to the maintenance of a continuously open channel of communication between homemaker/home health aide and professional supervisor, and the effect upon this relationship of other responsibilities for training, direct services to recipients of service, and joint activities with other professional staff.

Administrative Responsibility for the Homemaker/Home Health Aide

The administration of the service which employs the homemaker/home health aide is directly responsible for the activities of the homemaker/home health aide, and the homemaker/home health aide is responsible directly to the administration.

Homemaker/home health aide training, when it is provided by arrangement from sources outside the administration, does not alter this relationship. When professional supervision of specialized aspects of the homemaker/home health aide's activities in the care plan is provided from sources outside the service, that supervision does not alter the relationship of the homemaker/home health aide to the service which employs her, although she may receive functional supervision from outside sources in these specialized aspects.

This responsibility is strengthened when homemaker/home health aides are assigned administratively to agency employed supervisory staff, and when the role of specialized consultants or participating professionals from other sources has been defined. This definition must be clear both to the professional and to the homemaker/home health aide. A consulting physio-therapist will not expect the homemaker/home health aide to undertake

activities which are contrary to agency policy if she is familiar with that policy; and a homemaker/home health aide will not accept responsibilities which are outside the scope of her role as it has been defined by the administration of the service.

Professional direction from sources outside the service when they involve necessary exceptions to service policy, or deviations from established service practice, are therefore channeled through the administration and incorporated into the individual service plan as administrative decisions, precisely formulated as to application in terms of current or future practice. Exceptions are administratively framed as they relate to an isolated situation, to a particular group, or for a specified period of time. The implementation of administrative responsibility is one of the functions of agency employed professional staff.

Interdisciplinary Practice and "Dual" Supervision

When an array of professional services is involved in the care plan, questions arise as to the role of the various professionals in their supervisory relationship to the homemaker/home health aide, and in their activities as an interdisciplinary team.

If the objective is a merging of professional skills in a comprehensive plan of care, it is evident that professional direction must not come to the homemaker/home health aide as a series of parallel and possibly contradictory orders. The plan in which the homemaker/home health aide participates, and which she must in a large measure implement, must be presented to her and directed as a single staff effort—with emphasis, perhaps, on certain aspects, but with coordinated practice and objectives.

If, for example, the goal is physical rehabilitation so that activities of daily living are restored, specific emphasis may be placed upon a physical therapy regime. The general health status of the individual, evaluation of personality, the importance of attitudes toward the routines of therapy, the emotional climate in the home, and the importance of the physical environment as an extension of the individual way of life, are all germane to the plan and must be understood as important factors. Since coordination must then be more than an idea, administrative and procedural mechanisms must be established to put the idea into practice.

These mechanisms begin with precise job descriptions of each staff member or participant in the care plan, in which the specific role within the context of care is appropriate to the participant's function. What the nurse does, and what the social worker does, in general will not be effectively implemented unless functions are specifically delineated in the various stages of service: admission, evaluation, development of the care plan, implementation of the care plan, termination, the role in training, and activities related to administration and the community.

A second step will be the development of procedures which ensure coordination. Agreement that no staff member will engage in *unilateral action* in relation to the care plan, except in narrowly defined areas of professional competence, is one. The social worker in this context may not instruct the aide that certain health care procedures may be temporarily ignored because of a change in attitude toward them on the part of the recipient, unless there is a joint agreement that this is desirable. The nurse may not advise the homemaker/home health aide to "let the housekeeping go," to "skip" planned excursions intended to relieve monotony, or to increase participation with others, unless this is a joint *decision*. Changes in scheduling of time or the assignment of duties are joint decisions, as is reassigning a homemaker/home health aide because one member of the team believes her to be inadequate in a particular set of skills—she may have become important in the home in other ways. Most important, the decision to terminate service—"because personal care is no longer needed," or "because the recipient cannot make appropriate use of the service," or is "manipulating"—which is often tempting in the heat of the moment, must invariably be postponed *pending joint agreement and joint planning*.

Independent direction *within* the defined area of competence is, of course, essential. Some of these areas may be changes in treatment, i.e., from bed bath to tub bath; recommendations for increased ambulation in the health care plan; the decision that the homemaker/home health aide may take over complete responsibility for child care to free a tense parent for an afternoon. Assisting the homemaker/home health aide by helping her to express in an acceptable way, methods of improving child care or home management; involving the homemaker/home health aide as a supplement to professional interviews which assist families in accepting termination or placement (when these are plan objectives) are examples of appropriate independent professional activity—always predicated on the understanding that they will be integrated into a joint approach to the care plan.

If open channels of communication between the homemaker/home health aide and the professional are essential, procedure must also take into account the fact that emergencies may arise when the appropriate staff member may not be available. In emergencies, the homemaker/home health aide must be assured that *any* professional staff member will respond. Agreement should be reached by the professional staff with the administrator as to what constitutes an emergency (experience usually helps to determine this) and what the immediate response may be.

A policy which is basic to the concept of administrative responsibility requires that a responsible professional staff member will

be available to the homemaker/home health aide staff at all times; in other words, that there is continuous professional "coverage" in the event of emergencies. The general mandates concerning the relationship of professional staff to homemaker/home health aides are that no professional conflict of interest may ever be expressed to the homemaker/home health aide, and no homemaker/home health aide may be asked to accept responsibility in a crisis or emergency which is appropriate only to a professional staff member.

When definition and procedure are effective, the problem of dual or even multiple supervision of the homemaker/home health aide is less likely to arise. This must be supplemented in training to develop an understanding of the various professional roles so that the aide will turn to the nurse in problems related to health care—i.e., when the physician has not been clearly understood by the recipient, or when problems with medication or personal care arise. Or, she will turn to the physical therapist when she has problems with equipment or when routines are being neglected. She will seek out the social worker when changes in the emotional climate or behavior are observed, or when a need for community services becomes apparent. Homemaker/home health aides who are well trained become experienced in turning to appropriate professionals for direction.

Many agencies designate a staff member as "supervisor" of a group of homemaker/home health aides. She becomes the professional staff member to whom the homemaker/home health aide turns with general problems. In this instance, when other professional services are involved in the care plan, the supervisor becomes an advisor and usually carries administrative responsibility for the activities of the aide. She must sustain effective relationships between the aide and other professional participants in the individual care plan.

Occasionally the team participants may designate a professional staff member as coordinator or supervisor in an individual situation, according to the primary emphasis in the care plan. The aide must, of course, understand the functions of the various staff members in this as in any other arrangement.

Evaluation of the Homemaker/Home Health Aide

The homemaker/home health aide must not feel that she is dependent upon kind remarks or occasional frowns to know "how she is doing." Regular evaluations, jointly considered by the professional staff, should be a part of agency practice, forthcoming at regularly scheduled intervals. Usually a trial period is specified upon employment, followed by an evaluation. They may subse-

quently be scheduled at six month intervals, followed by annual evaluations for experienced aides.

Periodic evaluations should be explained as a matter of course: a part of the aide's status as a staff member, and as a pattern which prevails for all staff members (as it should). She should expect that they are intended to increase her capability, and are not meant as personal criticism; the evaluations should be presented in this atmosphere. She should understand that they are the result of a joint effort, although a single staff member will usually discuss the evaluation with her, and, as in professional evaluation, she will be allowed to present her point of view. Homemaker/home health aides who are "counseled out" of the service should, as far as possible, be helped to understand that this does not imply total inadequacy for all employment, but simply problems with a particular set of attitudes and skills.

Emergency separations of an aide are occasionally necessary. If selection and training are of good quality, this should be a rare occurrence. During the period of orientation and in subsequent training, those rules which are arbitrary in agency policy are repeatedly stressed. The aide must understand that if she acts independently in the matter of medical orders, in alteration of the care plan, or evidences unacceptable behavior she will be separated from service. When this does occur, unless there are important mitigating circumstances, separation should follow immediately. "Mitigating" circumstances refer to misunderstanding of the schedule or a demonstrated confusion in orders, for example.

All homemaker/home health aides have a primary responsibility to recipients of the service, and the importance of this central goal must not be set aside. Violations of policy with respect to safety in the care plan are therefore more important than friction between the aide and individual members of the professional staff. Homemaker/home health aides are taught that people are different, and not everybody likes everybody else. When dislike at the staff level occurs, aides should, if possible, be tried with different supervision or personnel. Such a change should be made without prejudice, as it is in the care plan when such situations arise.

ADMINISTRATIVE RESPONSIBILITY

Administrative responsibility in establishing an effective pattern of group activity within the service can be summarized as having a three-fold objective:

The development of mechanisms through which continuing administrative familiarity with service functions is achieved;

Regular attention to increased quality at the point of homemaker/home health aide service delivery; and
Maintenance of a program of professional staff development focusing upon professional and procedural service quality.

The Administrator and the Staff

Administrative participation in conferences and staff meetings, when they are conducted in a relaxed atmosphere, is an important tool in the review of policy and the maintenance of quality. These may be regularly established meetings with service supervisors; they may be periodic meetings of all staff for general review of the service; they may be meetings with selected groups: homemaker/home health aides, nursing staff, or social workers; or they may be occasional informal visits to "sit in" on a team conference or the staffing of cases. The "structuring" of such participation is an important consideration for the administrator. He must be clear about his own intentions in this effort, and must be prepared to conduct himself accordingly.

The regular administrative staff meeting, which is established practice in so many agencies, with its agenda, committee assignments, and reports, can become dangerously ineffective as a real way to understanding what is happening in the service if it becomes a mechanical "must." The administrator's eyes and ears will be his best guide if both are in use at all times. Meetings which get bogged down in procedural detail which is best handled in other ways; meetings which make use of "outside speakers" because there is nothing else to do; or meetings used as convenient vehicles for the "objective" expressions of personal dissatisfaction better presented in individual conferences, contribute very little to the administrator or the staff. Every meeting should be preceded by the question "Is it necessary?" The decision to space meetings more widely in time, or to hold them on demand, is good administration when it is arrived at honestly.

Meetings of the administrator in regular service group conferences may or may not be a regular practice. In many services it is not, and there is a valid basis for this decision. Here the daily functions and the professional aspects of service are frequently the major focus of discussion, and the invariable presence of the administrator, whose center of interest is different, may inhibit the free development of imaginative approaches to service. He may come when he has a functional purpose, when he is invited to help in problem solving, or when he is interested in increasing his own knowledge of discussion content; his purpose must be clear in any of these choices.

Meetings of the administrator with homemaker/home health

aides as a group is an activity which is almost invariably rewarding if the "chain of command" exists only as a connective link and not as a barrier to free expression. Homemaker/home health aides are interested in present and future plans; they can and do have practical and valuable ideas about policy and procedure; they can understand financial problems; and they are generally the most available link to the community. They spend a great deal of continuous time with service recipients and are often deeply involved with community consumer groups. Sharing information and listening are functions of primary administrative importance.

"Sitting in" on individual and staffing conferences is just that. The administrator has no authority; he is a participant; he may not be able to contribute as much as the homemaker/home health aide since he will usually be unfamiliar with the details of what is being discussed. When this practice is frequent enough to be generally accepted, and when it is clear that he is not judging or evaluating staff in the employer-employee sense, he will blend with the environment and learn where the real problems in daily practice are.

The Staff and its Meetings

If the administrator has a variety of responsibilities in his meetings *with* staff, he has an even more important responsibility in his concern with their meetings *without* him. The number of meetings and the amount of service time consumed in meetings may become a problem when there are several disciplines involved in the provision of service, and must always be considered. Each professional group has its own conception of staff development. Each profession has a conception of its role in the training and supervision of the homemaker/home health aide. All professions have an interest in joint activity. When meetings and conferences are regularly scheduled to meet these requirements, it is conceivable that in addition to administrative meetings, staff meetings and conferences may occur several times each week. Administratively these must be evaluated in terms of their true usefulness and purpose and in terms of agency priorities.

Perhaps the order of importance might be stated in a way which emphasizes service aspects. This places a high priority on group activities aimed at increasing the judgment and skill of the aides. Orientation sessions, group discussions, "refresher" training, and individual and staff conferences in which each care plan is reviewed and evaluated are among the activities which are routinely planned. Inseparable from these are the joint professional meetings which develop a smoothly functioning interdisciplinary approach to care.

Professional staff development specifically geared to separate areas of professional competence and continuous review of the ways in which practice and procedure affect the goals and purposes of the service may be less routine but cannot be forgotten or ignored. They have their best effect when they are related to present or future service needs; when they are developed out of the staff's direct expression of interest; and when they are planned with a continuing awareness of the service responsibilities of the staff.

PERSONNEL PRACTICES

The conditions of employment are intimately related to the quality of the services which the staff provides. No matter how well trained, no matter how adequate in supply, no matter how fortunate the relationships, an inevitable "souring" develops when personnel practices are unfair, vague, or so variable that staff members do not know from day to day "where they stand." Every employee has a right to know, from the administrative section of the service program, the conditions of his employment. Quality services therefore establish personnel practices for homemaker/home health aide services which conform to professional standards.

The various professions have established standards which guarantee reasonable personnel practices in employing agencies. These cover rates of pay, hours of work, vacations, sick leave, unemployment and disability insurance, and frequently "fringe" benefits (health and welfare plans). Clerical staff may not invariably command the same protection. However, because of acceptance of essential skills, it enjoys a reasonably protected set of working conditions.

Although national standards for homemaker/home health aide services have emphasized the importance of similar practices for aides, working conditions do not invariably meet the standards that prevail for professional and clerical workers in these programs. This is probably due in part to a residual attitude toward homemaker/home health aide employment as "menial" or casual domestic labor; in part it is based in the continuing financial insecurities of such programs. Programs under voluntary auspices, which rely to a large extent upon the charitable gifts of donors, do not consciously recognize the fact that they also rely substantially on the unwilling charity of a poorly defended group of workers who often provide with their services, a subsidy in the form of irregular and sometimes bizarre hours

of work; pay scales based upon minimum or below minimum or "going" rates for unskilled workers; little regard for the normal need for rest in the form of paid vacation; little consideration in periods of illness; and little protection in periods of unemployment. Public opinion tends to view the aide as "unskilled" when pay scales and conditions of employment are under consideration. Simultaneously, homemaker/home health aide programs are described to the community as those which provide aides who have been selected because of special personal characteristics and who have been trained to perform with a degree of skill and dependability.

Aside from considerations of justice, there is very little safety in personnel practices which sustain this paradox, and the reckoning usually comes in subtle resentments, unreliable performance, and expensive staff turnover, all finally affecting service quality, community acceptance and support. The frequently stated contention that the cost of good personnel practices will mean reduction in service and even elimination of the service as a community resource is self-defeating, since a service which must be sustained at the expense of its most essential and least privileged workers is hardly worth "selling" to the community with any degree of pride. If it is worth having, the community must know and be willing to pay the price; if the service must be limited in size and scope by the establishment of good working conditions, the requirements for extension will be understood in those terms.

Rates of Pay

These are established as monthly salary at an hourly level which is above the "minimum" rate and well above the rate for casual domestic work. Usually they are scaled to provide regular increments at stated intervals when satisfactory performance has been demonstrated. A probationary period or period of orientation is established at the first step in the pay scale. A second step is usually achieved upon satisfactory completion of "core" training. Thereafter, at pre-established intervals, the hourly rate is increased until the maximum rate has been reached.

When special categories have been established for skilled workers as a "career ladder" opportunity, workers who are asked to assume responsibilities more nearly allied to those of professional staff enter a new pay scale range, again with an established base and provision for progression through the pay scale at regular intervals.

"Hourly" or "guaranteed" work refers to homemaker/home health aides having the same qualifications as "regular" (full-time) employees, but employed on a part-time basis. A specified

number of hours is guaranteed and paid whether or not the agency uses them, and the total number of hours worked is computed and related to earned vacation, sick leave and other benefits.

Hours of Work

The work week which prevails throughout the agency is the established work week for homemaker/home health aides. Hours which may occasionally be required in excess of the "normal" work week are paid with an increment for overtime, as are special assignments for night hours or weekends. Twenty-four-hour care which is provided as a regular part of agency services is computed at a special rate, allowing for meals which may be taken in the household, and taking into consideration the fact that concentrated effort is not usually required throughout the 24-hour period. If the demands are unusual—i.e., frequent night services or exacting and continued personal care—rates of pay will approximate more closely those of a professional similarly employed.

Rates of pay in 24-hour or "live-in" assignments are not reduced on the premise that this provides the aide with a "home," since such assignments are rarely a substitute for the aide's own home, which must be maintained and to which she will return when the assignment is terminated. In these instances, the work week is computed so that the aide is allowed regular daily rest periods and at least one and one-half days each week free of responsibility for care services.

Vacation Time

Paid vacation time is provided usually upon completion of a given period of employment (six months to a year). It may be related to the number of months worked (one-half to one working day for each month), or may be allowed on a calendar basis and increased to a maximum at the end of an extended period of service: one week each year after the first year of employment; two weeks following the third year of employment; to a predetermined maximum. Some agencies have established the policy that all staff, professional, clerical and homemaker/home health aide are entitled to the same vacation allowance; this policy is very effective in the development of good staff relationships.

Sick Leave

The health needs of homemaker/home health aides have a high priority in agency service, and the established prohibition against working "with a slight cold" or other seemingly minor disabilities is sound. Sick leave is therefore not considered an earned benefit

in the same sense as vacation time; the allowance of paid sick leave (one-half to one day for every month worked) begins with the first day of employment. Increasingly, homemaker/home health aide programs are contributing to health insurance plans for all staff. This is an important "benefit," usually as important to the service in terms of employee satisfaction as to the aide.

Unemployment Insurance

Not all voluntary agencies make this benefit available to employees; the concept that homemaker/home health aides in particular are "casual" domestics who need not be covered is destructive to security and consequently to quality of service. Homemaker/home health aide services are peculiarly prone to sudden changes in staffing based upon budgetary insecurity. This becomes less difficult and ensures the return of well trained staff when there is protection for the aide in periods of unemployment.

Payment for Travel Expense and Travel Time

The expense of travel (by common carrier or automobile) as the homemaker/home health aide goes from one assignment to another is paid by the service, except for home to office at the beginning of the day and office to home at the end of the day. When the office is not the daily "base" and the aide must travel long distances to or from her first and last assignments, exceptional travel allowances are provided. Travel time, that is, the time required to travel between assignments, is paid at the regular hourly rate.

The procedure for paying travel expense and travel time can become administratively cumbersome, involving "expense sheets" and records which must be audited for relatively small amounts. Some agencies prefer the practice of computing an "average" monthly cost for these items, including them in the hourly rate of pay. This policy must be clearly understood as expense to the aide and not considered when the hourly wage is in question.

Uniforms

Uniforms are paid for by the agency—usually three to each homemaker/home health aide, with provision for replacement. Aprons, bags and supplies are also provided.

Other Benefits

Some services offer retirement plans; these are available to homemaker/home health aides as to all staff. Special arrangements for "career" training, remedial training for language skills, and training which provides an opportunity for aides to become clerical

workers in the service, when they are available are explained at the time of employment and preference is given on the basis of both seniority and aptitude. Homemaker/home health aides may then look to such possibilities as alternatives in terms of interest and increased earning capacity.

Personnel practices are based upon the principles that whatever is required of the homemaker/home health aide by the service will be paid for at a fair rate; that working conditions will be established which protect the aide as a skillful and essential worker identified with agency goals and important, as every other member of the agency staff is important, in a joint effort to provide effective services in the community.

SERVICE PROCEDURE

The "Scheduling" of Homemaker/Home Health Aide Time

Sound practice in scheduling emphasizes the assignments in the amount, and at the time of day or week, that are the most effective in terms of service need rather than as a by-product of scheduling convenience. In their assignments homemaker/home health aides cannot function effectively if they must rush from one assignment to the next, or if they are expected to carry numerous heavy assignments in the course of a single day or even a single week. Care in scheduling involves variation in assignments: i.e., an assignment which is complex or physically difficult alternating with one that is less demanding.

The plan of care must always be reviewed to determine that the expected duties are reasonable in terms of the time allowed; and that homemaker/home health aides are allowed sufficient travel time, time for meals, and brief rest breaks during longer or heavier assignments. Recipients of service should understand the necessity for such practices.

Sound practice with respect to scheduling is also based upon the principle that the best service will be achieved if aides as staff members are entitled to payment for a full work week, whether or not the agency is able to use the time. Unscheduled time may be used for training and conferences when this is administratively possible. Homemaker/home health aides who are employed as part-time staff should be employed for a *specified* part of the day. They should not be required to be available for service at any time that is convenient to the service. Conference and training time are not productive when scheduled at night after a working day or on weekends, and are never considered "volunteered" time, but are scheduled and paid for as a part of regular hours of work.

Administrators of homemaker/home health aide services, particularly those which offer part-time service, are plagued by the problem of making maximum effective use of the homemaker/home health aide's time. The division of a working day into sections which allow for travel time and provide practical blocks of time in the home is difficult. In those services which guarantee homemaker/home health aides full time employment, unavoidable loss of time because of scheduling difficulties contributes substantially to the cost of the service. When three hour assignments on alternate days are necessary in a majority of the care plans, there are problems in scheduling the two remaining days.

Occasionally, procedural or policy devices are used to minimize the loss: a policy which insists on a minimum half day assignment (dividing the day into two equal assignments whether the recipients need the time or not) is one; another is the "not more than four hour assignment" as a policy (six hour assignments may leave two unusable hours at either end of the day). Still others compress the time in the home into a series of one or two hour assignments (emphasizing personal care only or narrowing the plan to what is minimally required).

More than any other factor, scheduling problems influence the programs which employ homemaker/home health aides by the hour, paying only for those hours which can conveniently be used. This is self-defeating, since such casual employment does not encourage aides to identify with the agency, and staff turnover wastes an important investment in training.

Such waste will probably not be eliminated until homemaker/home health aide services are accepted and supported as an important and valid part of the community's resources. In the present circumstances, the best approach is one which frankly acknowledges to the community the true facts: "dead" time is inevitable and must be included in service costs.

These are considerations in the use of aide staff time which, in parallel terms, are a normal part of the agency's relationships to professional staff. Homemaker/home health aides participate in the delivery of quality services to the extent that they are considered, and consider themselves, an essential element in these services.

Forms

The use of forms in the service program is not always as efficient as it may seem. Forms have a dangerous tendency to multiply, and they can obscure the true history of service activity. This is avoided when a central mechanism for forms control has been established. There is then the understanding that no single indi-

vidual or professional group may unilaterally establish a new form. A service form may be developed by the administrator or by the staff and presented to an individual or group charged with the responsibility for determining that it: serves a useful purpose; is needed for situations which occur frequently; does not duplicate information already available; and does not alter the purpose of other recording practice. This, of course, implies that there will always be staff participation and staff concurrence in the initiation of new service forms.

Forms which have been initiated for specific administrative purposes require, if possible, a more careful approach than those used in recording. It is always a temptation to "simplify" or to ensure accountability by the laying on of a form for the purpose, particularly when the initiator is not involved in service activities. The question "Is this form absolutely necessary?" should be asked seriously, since the completion of every form takes valuable time from the delivery of service.

The convenience of non-service personnel must necessarily be a secondary consideration when it is weighed against the need for appropriate use of professional and homemaker/home health aide service time. Completion of forms imposed by the various agencies which purchase service need not necessarily be made the responsibility of service staff; where they require the same information but differ in their structure, information can sometimes be drawn from the record in a single comprehensive document which is used by clerical staff for form completion. It may also be possible to suggest a single comprehensive form if concerted community agency action can be mobilized.

Forms may often serve more than one purpose, and consideration of this possibility is always important. When multiple copies are to be routed for billing or statistical purposes, or for the use of those not directly involved in the service plan, some standard with respect to the use of the information and the method of routing are most effective if there is a period of testing followed by the establishment of a mutually understood procedure.

FINANCIAL MANAGEMENT

The financing of homemaker/home health aide services has been a continuing problem complicated by multiple and frequently unreliable funding sources—both public and private—based on limited appropriations, occasional contracts, difficult third party payments, fees for service, or gifts and allotments from voluntary community funds. The full potential of in-home care will be

realized only when recognition of its importance as a component in comprehensive community services is accompanied by the establishment of a stable source of financial support.

The Budget

Despite these problems, the program budget must be built rationally so that planning is possible, established policy is sustained, and the community receives reliable information concerning the expenditure of funds.

Usually, program financing is planned by establishing the cost of a unit of service, and projecting the number of units of service which can be provided from total funds available within a given period of time. Programs vary in what is considered a unit of service. This may be a "visit," or it may be more narrowly defined as an hour of service (since the length of a "visit" may be variable and does not lend itself as readily to assignment of costs).

The simplest method of computing the cost of a unit of service is one which is inclusive. The total agency budget is divided by the total number of units of service delivered, and an average cost per unit is then established. For example, the funds available for the agency in a given year may be:

United Way	$ 65,000
Foundation Grant	25,000
Estimated third party payments	45,000
Estimated fees	14,000
Contract service	35,000
Total agency budget	$184,000

Disbursements are planned as follows:	
Overhead (rent, light, heat)	$ 18,000
Administrative Expenses (Administrative & clerical salaries)	28,000
Professional salaries (full, part time consultants)	33,000
Homemaker/home health aide salaries (equivalent of 17 full time)	85,000
SDI, FICA, Insurance Travel Uniform replacement Supplies	20,000
Total	$184,000

It may be estimated that 17 homemaker/home health aides will provide approximately 25,000 hours of service (based on last

year's experience) : an average of six hours per day with one hour for travel and an average of one hour unscheduled or used in training and conference time.

The cost of a unit of service will then be: $184,000 divided by 25,000, or $7.36 (the hourly cost including all costs; administration, overhead, the cost of professional supervision and training). This unit cost may be used to project the funds which are necessary in order to increase the volume of services next year. It may also be broken down to show the percentage costs in an hour of service:

Homemaker/home health aide's salary	46%
Professional supervision and training	18%
Administration and overhead	25%
Insurance, travel, uniforms, supplies	11%

Services which are free standing use this method easily, since total budget and total services can be identified. When the services are placed in a parent agency, percentage costs are computed on the basis of the proportionate use of space, heat, light, and professional staff, which may be partly drawn from the parent agency and assigned to inclusive cost.

The purchase of services by insurance or other third party sources may impose a different method of computing costs. If professional services are purchased for "direct" care to the recipient (nursing, social work, physical therapy, occupational therapy), the hourly cost of professional staff and expense is computed and each "direct" professional visit is charged on the basis of the amount of time spent in the home. That portion of the professional time spent in supervision and training of the homemaker/ home health aide is then assigned on a percentage basis to the inclusive cost of an hour of the aide's service.

Fees

Contracts and third party agreements pay full cost based on the unit of service and/or the cost per visit. In the sample budget there is very little leeway for reduction of the unit cost. Homemaker/home health aides will earn at least the minimum wage plus increments. Some economies may be possible if part-time care is not the prevalent pattern and longer assignments eliminate travel time and unscheduled time. Professional supervision requires one full-time professional salary for 8 to 13 homemaker/ home health aides with funds for training, consultation and service from allied professionals. A single full-time administrative salary and clerical salaries account for less than one-fourth of the budget.

An honest approach to the real cost of the service when it is presented to the community is as important as is the presentation of real institutional costs. The "selling" of in-home services as "cheaper" than institutional care does a disservice to homemaker/home health aide services in the long run, limiting their potential development as quality services which are provided because they are appropriate and not because they cost less than institutional care (although they may in many instances be less expensive).

Policy with respect to fees charged to individuals does, however, play an important part in achieving community acceptance and support. "Community" services are understood as resources which are not restricted to those who can reimburse in full. The administrative dilemma is the management of the service so that individual fees will be based upon ability to pay at the same time that income from fees which partly support the service is kept at a safe level. The devices which are used to achieve this compromise include the assignment of a fixed percentage of the total hours to no-fee care, and a similar assignment to part-pay care, establishing an average anticipated income from part-pay reimbursement.

This places some responsibility upon the admitting staff, which must then select on the basis of priorities those no-fee applications which seem most urgent, and which must balance a minimal reimbursement plan with one that comes closer to full cost in order to maintain an average in the part-pay group. Eligibility practices of this kind must also be honestly presented to the community so that additional support for the disadvantaged sector is understood as a community responsibility.

DATA COLLECTION

A systematic program of data collection is absolutely essential to program planning, program management and community education. Both the administrator and the community must have reliable facts which identify the number of individuals (or families) served, the characteristics of the group receiving services, the nature of the need for services, the volume and type of services provided, and a general outline of the pattern of utilization. Data describing the characteristics and need of those applicants who, for given reasons, were not accepted is equally important.

This information, accumulated year by year, becomes an indicator of service trends as they relate to policy. It also provides the basis upon which the capacity of the service can be projected or extended. From continuing data use, patterns will emerge which indicate that an average number of hours of service are necessary from the point of application to termination. This average, multi-

plied by the unit cost, will indicate the possible projected caseload. Patterns of use in specialized areas of need may be arrived at and used to project costs for extension of the services to applicants not currently covered either by policy or because of fund limitations.

Attitudes Toward Data Collection

Systems of data collection, when they are considered, tend to produce responses of two kinds, depending upon the interests of those who plan them. The attitude which views data and all of its enchanting possible variables as a magical solution to planning, offering unlimited opportunities for analysis and interpretation, is one. It is stimulated by a current preoccupation with the computer as an inanimate but powerful thinking mechanism. Another, which is the result of a growing disaffection with mechanization, repudiates numbers in favor of feeling, as if information and human concern must be mutually exclusive.

The administrative bent tends to the first view; practice to the second, and when these opposing attitudes coexist in the same service, a system for the collection of data is apt to suffer from overemphasis on the one hand, and subtle resistance in the form of sporadic or inaccurate recording on the other.

The System Adapted to Service Goals

If an accurate and functioning information system is to survive and produce, it must be based upon a series of important premises. These emphasize the service goals and the practitioner's devotion to service as primary. Data collection will always be secondary to service, and will be planned as a by-product of service. It will be planned so that with simple procedures, consistently adhered to, only the most essential information will be collected. It will be integrated with normal service procedures, requiring no additional effort from service staff; no filling out of special statistical forms; and no afternoons spent in the office counting and tallying and entering in books or on charts.

Such a system requires initial planning so that the necessary information is "spun off" from the forms and records which are normally used by service staff. Working records are not taken over from service staff for counting purposes. The use of carbon paper or multi-purpose forms frees a statistical copy of key documents so that all counting becomes a separate function, the results of which are ultimately presented as a useful and informative tool for those who provide the service. The system is planned so that it will lend itself to simple hand tallying in smaller programs and may, with very little adaptation, feed information into machines in larger and more sophisticated programs.

Usually, basic data collected answer the questions:

Who is being served?
What is the nature of their need?
How many people are being served?
Who referred them?
How many services are provided?
What kinds of services are being provided?
What is the duration of service?
Why is service terminated?
What are some of the measurable effects of service?
Who is not being served?
What is the nature of their need?
Why were they not served?

Each of these categories of information requires a clear definition, which is established prior to the initiation of the system and is consistently applied.

The assignment of an identifying number to each applicant for service, usually established in a master index file, will serve to coordinate all activities related to that applicant. Thereafter, if there is a fairly systematic pattern of work, and working documents are planned so that the essential information appears in a logical sequence (usually logical for the practitioner as well), a reliable routing pattern may be established. Copies of pertinent documents will arrive at the collection center to be coded and filed in a central place for periodic sorting; and counting and assignment to pre-established tables, either by hand, by key punch and sorter, or by a computer system.

In practice, the initial application or face sheet will usually contain all of the essential identifying information: name, age, sex, geographic area, family composition, referral source, economic status, and presenting problem. This single document may become the source of cumulative information concerning caseload characteristics. The decision to accept or reject, and the initial service plan, may be recorded on this or a subsequent service document. The volume and type of services may be drawn from copies of time sheets, work tickets, and/or copies of bills. Termination and the reason for closing may be recorded on a closing notice, or a closing summary, a copy of which may be routed when it is recorded in the working record. Re-applications, cleared over the master index file, will eliminate duplication of numbers and will ensure an accurate count of the individuals served.

The system's accuracy will rely upon designated categories of information to be collected; clear definition of the meaning of each; a selected series of key working documents which will invariably be routed to the collection center; and a set of pre-estab-

lished tables which are intended to provide cross tabulations for purposes of planning, evaluating policy, identifying unmet need, accountability, and interpretation to the community.

Such cross tabulations can tell the story of the service very effectively: Are families with children the most numerous recipients of service? Do they use more hours of service than adults? In which diagnostic categories is the duration of services extended? In which is service short-term? Are single person families more prevalent than family groups? Are more women in need than men? Do applicants tend to come more frequently from a single area of the community? From an upper, middle or lower income group? In which diagnostic groups are direct professional services more heavily utilized? Are referral sources concentrated in a single set of agencies or institutions, or does the community at large give evidence that it recognizes the agency by referring relatives or neighbors? Is service terminated more often because of improved status or because of the need for placement? Has the total population served increased without a corresponding increase in staff? Has short-term service increased without a corresponding change in presenting need? If so why? More efficient use or a possible deterioration in the quality of evaluation? Are the characteristics of those rejected for service similar or vastly different from those accepted?

Such questions are not simply a field for academic speculation. When properly evaluated, they replace conjecture with objective information about the program as it functions, its effectiveness and its future. It is basic to community understanding and ultimately may go beyond the community to establish the necessary broader understanding which has been so slow to develop.

SUMMARY

The responsibility of the administrator for the quality of the service depends upon a sensitive approach to those areas of need which cannot be guaranteed entirely by mechanical "devices" to assure quality. Standards with respect to levels of professional skill; procedures which establish consistently scheduled supervision of the homemaker/home health aide; continuing evaluation of the home care plan; reassessment of the health and socio-economic status of all service recipients; and the maintenance of sound initial and refresher training are *methods* for the safeguarding of service quality.

Yet the quality of sensitivity remains important to homemaker/home health aide services. The effectiveness of the service is built upon a continuous and close set of relationships which take place

in a setting that is personal terrain. A man's home is, in truth, his castle. Thus, service personnel—most particularly the homemaker/home health aide—may become the outsider, the interloper upon whom, nevertheless, the plan must depend to further a positive psycho-social health care plan. Such relationships have great potential—for destructive friction as well as for a wholesome outcome.

The responsibility of the program administrator extends beyond the comfortable assurance that the structure is "right." In addition, his assurance is built upon a constant awareness of myriad small events: the overheard inflection of a voice on the telephone, a phrase used in opening or closing a case, attention to the characteristic evaluative approach of various staff, and the degree to which staff members seem to understand one another. It is gained from a sense of the general atmosphere of the agency as it affects homemaker/home health aides in their attitudes and skills; as they describe their assignments; their openness in expressing genuine reactions; and their identification with agency goals that go beyond a mechanical acquiescence in rules and regulations.

It is the "velvety" approach—the soft atmosphere, or the concern for the nonmechanical human adaptation of the necessary mechanics—that should give the administrator his best assurance of service quality. This means, of course, that the administrator knows *all* the staff members well and is comfortable about communicating to them a strong sense of the importance of quality service.

CHAPTER 7

The Pattern of Service

In homemaker/home health aide programs the services tend to fall into a pattern of delivery and use that traces the movement of recipients through successive stages of services. They may be classified under different names, but most service patterns develop in the following phases:

Application for service—"intake" or referral.
Evaluation—assessment of need.
Formulation of the care plan—assigning levels of care.
Implementation of the service plan—ongoing service; delivery of direct and supervisory professional services; homemaker/home health aide services; related services.
Reassessment—reevaluation, review, plan adjustment.
Termination of service—closing to care.

Approaches to each phase of service may be affected by the type of agency administering the services. The health care agency may complete the entire "intake" process in the home; the multiple purpose agency may place responsibility for a full application on an employee who is familiar with the family but is not on the in-home services staff. There are a variety of approaches to assessment, care planning, and termination, but the sequence remains much the same. What is important is that the processes by which the recipient moves into and through services are well established, uniform and clearly understood. The pattern of service establishes the responsibility of each staff member at every stage so that questions as to who approved the care plan at any given phase do not arise.

APPLICATION FOR SERVICE

Requests for service originate in social agencies (or, where the homemaker/home health aide service is in a parent agency, from other sections or divisions of the agency); in health care facilities (outpatient clinics, rehabilitation centers, offices of private physicians, hospitals and nursing homes); or in "self" referrals (the individual requesting service for himself, or families, friends, or

neighbors applying on behalf of the individual who appears to be in need of services).

At the outset, the homemaker/home health aide program must take a position about the application process. Is it going to "screen out" or "screen in" applicants? Since homemaker/home health aide services are almost invariably short of funds, the temptation to tighten the channel of entry into the service is very great. Nervousness about money tends to filter down through the staff so that even the telephone operator may convey discouragement in the tone of her voice when a potential applicant calls.

Most new applications for homemaker/home health aide services are received by telephone. In child care, the need for homemaker/home health aide services usually first presents itself because of a crisis in the family. Adult clients are either at the point of discharge from the hospital, have become acutely ill, or have experienced an exacerbation of a chronic illness. Or, they may have been faced with a breakdown in their source of in-home care (domestic help, relatives, etc.).

Agencies which require written summaries and considerable "advance planning" as a *prerequisite* for service have, consciously or unconsciously, adopted a "screening out" policy. Since response to crisis in the home is one of the characteristics of quality homemaker/home health aide services, the practice of delaying service in the interest of "adequate" planning may in fact represent something quite different, unless emergency care is always made available in the interim. Nursing agencies frequently make at least one evaluation visit immediately following each telephone request. Telephone applications are only screened out following this visit. The sole exception might be said to occur in the case of institutional discharges. Since the patient or client is already under supervision, the decision to discharge him to his home can usually be made in time to allow for proper evaluation. (Friday afternoon clearing out of institutional beds may become a chronic sore point, since it may not be feasible to provide weekend in-home services on demand and the patient may be without resources; in effect "dumped," frequently to be re-institutionalized.)

The importance for the family of its first experience with the agency cannot be overemphasized. A great deal of time and thought must be given to the selection and training of those who answer the telephone—*all* telephones in homemaker/home health aide services, but most particularly that call which represents a first approach to the service. The objective is to find (or train) staff which has a genuine interest in offering information about agency services to *everyone;* has a thorough knowledge, not only of agency policy, but of the underlying rationale of that policy; has

willingness and skill with respect to referral to other staff or other resources for services which the agency cannot provide; and has the ability to take a good history without seeming unduly inquisitive.

These qualities are usually found in those who possess and can convey interest, and who are comfortable, open-minded, and not limited by the necessity to complete a form. It also requires a thorough understanding of the *vulnerability of the asker*, whether he is a professional, a disturbed mother, or a fragile, mature adult. It also requires a pleasant voice, one which carries natural rather than artificial warmth. Such paragons are not found ready made; however, those with aptitude are more readily available than might be imagined. Training will do the rest, and that training should set itself against the straight arm and the cold shoulder. An established procedure with respect to the information which is essential and that which can become follow-up responsibility will leave less opportunity for inconsistent or haphazard response.

New applications—whether from eligible or ineligible applicants—provide important information about community attitudes, service needs, referral sources, and the application process itself. The completion of an application is important on every inquiry, whether or not it is accepted for evaluation provided it is not obtained at the cost of the applicant's feelings. "As much as is volunteered or easily secured for purposes of screening" is a good rule. Procedure in some agencies requires that rejection of ineligibles must have professional concurrence; applications of those presumed eligible may be accepted for evaluation by nonprofessional telephone interviewers.

The Centralized Application Process

Receipt of telephone applications may be centralized. A selected staff is assigned exclusive responsibility for receiving all calls and making preliminary assessment of the appropriateness of the request. The call is received by a member of this group who makes a decision as to eligibility. Those applications which are clearly ineligible are not evaluated further. Those applications which appear to be eligible or are borderline are referred to the service staff for evaluation, planning and delivery of service.

A further step in the centralized application process may be the organization of a professional team which has exclusive responsibility for all evaluation visits to determine eligibility, and for the decision to accept or reject the application. This may be extended to responsibility for establishing the service plan as well. The completed "intake" is then referred to the field staff (often districted) to whom is delegated responsibility for all subsequent

services, supervision, direct care, reevaluation, plan changes and, finally, the decision to terminate service.

A centralized telephone application process requires the completion by the central staff of an application taken over the telephone which provides enough salient information to support a decision to make a home visit or to reject the application as patently ineligible. Its advantages are several: uniformity in the application of agency policy may be more readily achieved; central intake staff may be more accessible to administrative indoctrination and consultation; a more consistent policy about acceptance may be presented to the community; and policy changes with respect to eligibility may also be presented in a controlled consistent way. Finally, service control is more effective, allowing for acceptances as staff time becomes available and reducing the acceptances when staff time is less available or funding becomes difficult.

The dangers of the system might almost be said to be inherent in its advantages: the tendency to become over-identified with the administrative function—and correspondingly remote from the realities of life on the other end of the telephone; a drift into arbitrary application of the minutiae of policy; and a tendency to become mechanical because of the sameness of the assignment. The practice of centralizing the evaluation and planning processes may create a dissatisfied field staff; it may be difficult to follow through on a service plan which has been made by someone else. Evaluation depends to some extent on individual reaction. "I would not have accepted this case," is a response which, when repeated too often, may diminish interest in the delivery of quality services.

The Decentralized Application Process

In this process all requests for service are routed directly to the staff which will ultimately have service responsibilities. The telephone application will usually be screened by the staff member or by a member of the "team" which will make the evaluation visit, develop the service plan, and carry responsibility for that plan until services are terminated. In some instances the telephone application may be taken by a non-professional staff member under professional supervision.

This method has great advantages in that it assures continuity. Relationships begin virtually with the first exchange—and there is considerable enlightenment to be found in the initial expression of the problem, just as there may be support expressed in the first response to that statement. The evaluation and the plan proceed from those first impressions; and the services are the result of individual conviction about their appropriateness.

Its disadvantages, particularly in large or multiple service agencies, lie in the considerable variation which may occur in application and interpretation of policy and in maintaining control of service volume. Use of decentralized intake processes can, however, avoid the problems of variable interpretation when the staff is continuously familiar with policy. Volume of service may be effectively controlled by means of procedures which establish priorities or which assign new case quotas or blocks of service hours.

Office Applications

Office interviews as a part of the application process are not a prevailing pattern in homemaker/home health aide programs. They are used most frequently in multiple service agencies which require office application in their general services. They are also often used where the homemaker/home health aide service is an adjunct to general family services, and in situations where there is a parent or responsible relative available to complete the application. The interview itself is sometimes considered a part of the treatment plan. At the point of evaluation, however, a home visit is almost invariably made to assess feasibility and formulate the service plan.

Agencies sometimes adhere to a policy of office application because it appears to be a symbol of volition, or because it provides for an undisturbed opportunity to discuss the problems which have precipitated the request for service. The focus of the application for homemaker/home health aide services, however, is on the home care plan. Unless there is a real purpose in a required office application, homemaker/home health aide services do not lend themselves to remote planning, and may well be developed in the home.

EVALUATION OR ASSESSMENT

A distinguishing characteristic of quality homemaker/home health aide services is emphasis on evaluation or assessment of the potential recipient. This process involves considerable professional skill. Its objectives are to understand the background against which the present crisis has occurred, and to formulate *acceptable* plans to meet present and possible future need. It involves a careful definition of the present situation; of the temperament of the applicant and members of the household and their responses to planning efforts; and finally of the methods, procedures and staff which will be required from the service program and/or from other resources in order to ameliorate, arrest or improve the situation.

Most homemaker/home health aide programs (with the possible exception of commercial services) follow the established practice of visiting the home before planning services. Many agencies follow an almost inflexible rule that a professional visit to the home *must* precede the placement of the homemaker/home health aide. Exceptions may be made in emergency situations (abandoned children, helpless patients discharged from institutions without discharge planning, sudden illness, or incapacity requiring immediate assistance). In these emergency situations a professional staff member may accompany the homemaker/home health aide at the time of the first service visit. Where this is not possible, an evaluation visit is usually made the following day.

In any case, the professional visit, which the family may initially see as an obstacle to prompt service, can be one of the most constructive of all of the services that the agency provides. It should not, however, come after a delay of days or weeks, and it is not constructive if it is a perfunctory chore to meet arbitrary requirements.

The events which lead up to the demand for home care are usually derived from crisis and are destructive of normal living patterns. The suddenly insecure family or individual may feel that they are now separated from the "normal" members of the "outside" world and experiencing what seems to be isolation. Whether or not a home care plan proves to be feasible, the first visit to the home can have enormous effect in reconnecting the crisis-endangered household with the realization that there are tangible sources of support outside its walls.

The evaluation interview will in itself be therapeutic if it is held to the broadest, most open-ended pattern. The tendency to preestablish a mental set which is focused on agency policy and professional goals will usually be perceived immediately, and will have the effect of further undermining declining confidence and strength. It may also tend to suppress important information, often peripheral, which can be of great value in developing the care plan. The interview should be characterized by willingness to listen and to comprehend, comprehension being far more supportive to people in need than commiseration. Given this attitude as a basis for evaluation, the interviewer generally attempts to get a clearer account of the events which led to the crisis. Although this may have been presented briefly in the referral application, the evaluation visit is an attempt at more precise understanding.

Illness as the Presenting Problem

If illness is the presenting problem, it will be necessary in planning to know whether this has been one of a series of recurring

acute illnesses, the exacerbation of a continuing illness, or a first illness. Understanding of the pattern of use of health supervision is essential. The source of present or previous medical care must be determined, along with perceptions about medical care, financial barriers to its use, apprehensions about institutional care, and, most important, individual and family understanding of what has occurred.

Although it is a practice in health care agencies to have recorded medical "orders" for home care, it is still valuable for future planning to have the story retold by the individual *and* the family. A principle tenet of homemaker/home health aide services is that the individual who is to receive the care remains an individual, and is neither talked over or talked about. This is as true of the aged as it is of the young adult or the child. Since there is far less senility among the aged than is commonly supposed, and since it is currently recognized that there is far less innocence among children than was previously assumed, a healthy principle is one which establishes the recipient of the service as the most important person in the plan with primary rights in decision-making.

Thus, the flexible, open-minded interviewer hears what has occurred or is occurring, not in terms of a diagnostic stereotype, but in the personal context of daily living. Since this is the context in which the home care plan must be made, it must have equal weight with the professionally prescribed regime.

Following the interview, a decision might be made in several ways:

A home care plan will be feasible in agency terms. This might include initial daily visits by the nurse; homemaker/home health aide services half days for two weeks, decreasing to a long-term once weekly sustaining service; supportive psycho-social counselling and needed equipment leading utimately to resumption of restricted activities.

A home care plan will be feasible given "ideal" circumstances and a broad range of available resources. These might include supplemental financial assistance, better housing, psycho-social counselling, homebound physical and occupational therapy, nursing visits, homemaker/home health aide services beginning full time and decreasing as rehabilitation goals are achieved, nutrition counselling, meals-on-wheels, transportation for medical supervision, needed equipment.

A home care plan will be practical, but is not feasible in agency terms. This might be because of the need for daily nursing visits, not presently possible; full-time homemaker/home health aide services not available at the present time, or meals-on-wheels, available in the community but not on a daily basis.

A home care plan will not be feasible at this time. This might be because round-the-clock supervision is necessary but is not available. Physicians sometimes recommend home care in these situations, relying on the family to act as supplementary care personnel. On a daily, long-term basis this may create a family of invalids rather than a rehabilitated patient. The physical facilities for home care may be lacking: i.e., kitchen, toileting, or bathing facilities. Surprising efforts are frequently and successfully made in these situations, but there is a point at which a home care plan becomes a menace to health and safety.

Consideration of these various levels of care in assessing the problem may seem a waste of time, but its advantages will be immediately apparent to those who customarily make evaluation visits. The patient-oriented fertile mind begins to question. The prevailing thought becomes: how can the *optimum* home care package be put together, using all available resources and agencies?

Family Crisis as the Presenting Problem

These applications are usually presented as a need for child care; they are most commonly situations in which the need is sudden. Agencies providing homemaker/home health aide child care habitually place the homemaker/home health aide on an emergency basis, frequently during night hours, less frequently on a 24-hour basis (although this service has been demonstrated to have great value and to eliminate the need for the sudden change in environment which is often shocking to young children).

Again, the broadest possible approach is rewarding when the evaluation visit is made. The tendency to "talk" a better child care program than is delivered can occur when the time and staff pressures are heavy. It is often difficult in assessing the need for in-home child care services to get a clear picture, to discover what the family is really like. It is even more difficult, as recent studies indicate, to distinguish between what is desirable and what appears to be practical and achievable in professional terms. Where the service is being delivered primarily to a consumer group in which general cultural patterns are not too dissimilar from those prevailing in the agency system, assessment may not be less difficult—but the pathway to understanding is a more familiar one.

In evaluating need and planning care it is important to know what the *customary* interactions in the family have been, and whether or not all members of the family are presently in the home. Efforts to maintain an adequate standard of care depend upon such knowledge of previous patterns if those who are to sustain a home care plan are to do the job of "preventing family breakdown"—which has been a slogan in homemaker/home health

aide agencies over the years. As in health problems, it is important to get a *direct* account of what has occurred in the family's own terms, as against reports from outside sources such as agencies, neighbors or relatives.

Great stress has been placed upon the threat to the family when home care personnel take responsibility. The parent who cannot function for periods of time must not feel that he is being displaced by the homemaker/home health aide. This can be avoided if the parental role in the family is understood. The same understanding is important to children, who frequently feel themselves reduced to transferable objects in times of crisis. This may involve direct knowledge of previous contacts with crisis situations (illnesses, their own or their parents'), previous separations, sleep patterns, intra- and inter-family attachments, school history (evaluated in terms of who is telling it—often the child himself, given the opportunity, can tell it best), what the child enjoys most, and what he dislikes most.

The presence of an "outsider" in a family in crisis is in itself threatening, particularly to small children. Here, parents, when they are available, can help by answering questions about what can be most reassuring to the child (what has been helpful in the past). It is effective to visit the absent or incapacitated parent, whenever this is possible. Unless it is threatening to health, this may include visits to the alcoholic, drug addicted, jailed, emotionally disturbed, as well as the physically incapacitated parent who is out of the home and whose absence has made the child care plan necessary.

More and more homemaker/home health aide services are being provided in situations of great variety: in situations in which family crisis is common; and in homes in which efforts will be made to raise the living standard from very difficult to less difficult levels. Homemaker/home health aide services are being provided in homes in which parents with drug or drinking problems are present, creating suspected child neglect; and, though less often, in homes in which the "battered child" syndrome is suspected.

Because these are relatively new uses for homemaker/home health aide services, they challenge the imagination, frustrate the hopeful, and usually call for a good deal of joint planning, frequently with the homemaker/home health aide taking the lead.

Considerations in Assessing Need in Child Care

In the evaluation of child care situations, levels of assessment are identical with those in which illness is the presenting problem. The following additional considerations are worth emphasis.

In child care plans involving short term substitution of an adult

(the homemaker/home health aide) who will assume parental responsibility, the simplest plan may be the most effective. Neurotic patterns which are not extreme may be noted, and referrals made if necessary in those which appear to threaten stability. This may be as much as can be managed over the short period of service activity; attempts at "uncovering" (unless, of course, serious illness is suspected) may not be productive. A family which may have gotten along reasonably well in the past, even though certain problems are noted, may not in the long run benefit from a flurry of efforts at change without the possibility of sustained help.

The "difficult" family—i.e., one with multiple problems—tends to either classify itself as "not feasible" because total success is so infrequently achieved, or to engender the thought that homemaker/home health aide service can take care of everything. Assessment can best be based upon considerations of what might reasonably be done in the time and with the staff available. Well built, long-range home care plans have, in fact, been successful in seriously disturbed families. They do not as a rule produce overnight success.

The tendency in "culturally deprived" areas to make the evaluation in terms of stereotypes is always a danger. A group may be characterized as "poor"; such a characterization is not effective in evaluating the need for home care. Assessment is best related to the family in question and to its real need for the services which the agency is capable of providing.

The placement of child care homemaker/home health aide services in agencies which do not have health care consultation or ready access to health services (although some do have psychological services available) may lead to ignorance of the health status of family members. The emphasis may more frequently be on psycho-social factors; the emotional interaction in the family; or the effects of the present crisis on the psychic stability of the family. Child care home help is often effective (and is invariably described) as an influence beyond the immediate crisis in bringing new patterns of living to the family. The provision of access to health care and enlightenment about previously feared or ignored health practices are an important element in the services.

The evaluation interview, will be concerned with the general health of each family member. This can usually be determined by asking about health care, the date and purpose of the most recent physician visit, the immunization history of all pre-schoolers, and inquiry about recommendations (if any) made by the school nurse or school physician for all school-age children. Inquiries about eating and sleeping problems and about school attendance, as it

has been affected by health, may be revealing. Adults who are present in the home need not be exempted from this interest in health status. An interview which uncovers health problems may be the beginning of important preventive measures. The practice of asking the district public health nurse to visit regularly during the course of the child care plan is a good one; coordination of effort in instituting regular health care patterns is very effective.

THE HOME CARE PLAN

Usually the evaluation interview leads to a decision—either at the time of the home visit or as a joint interprofessional activity immediately following the visit—as to the probable feasibility of home care. Borderline situations may be accepted for a trial period with the understanding that other plans may ultimately be necessary. If, at this time, a home care plan cannot be worked out, possible alternatives are proposed to the family. Agencies which offer homemaker/home health aide services of quality usually provide assistance to families when planning for alternate care is necessary. The best of them assist in obtaining needed care. They make necessary referrals and continue to follow each family to the point where responsibility has been assumed elsewhere, or a solution to the problem has been found.

If a home care plan appears to be feasible, formulation of the plan itself is the next step. The plan is now made with more precise attention to the details of service.

Goals of the Home Care Plan

Although it may not invariably emerge in a total, specific identifiable package at the outset, it would be very difficult to make a home care plan without at least a tentative set of goals. The goal might be to maintain a level of stability, as in the development of a plan that will preserve the physical health and emotional security of a family in which one member is ill or absent; it might be to maintain the present physical, intellectual, and emotional status of an older person with chronic disease to prevent deterioration. Goals might be set in stages to bring about improvement or rehabilitation; to provide recommended treatment to acutely or chronically ill persons; to bring a bed-fast person to ambulatory status; to establish new dietary patterns for a diabetic; to assist a parent to follow treatment recommendations for a disturbed child; to teach home management; or to bring a malnourished isolate into contact with normal routines and ultimately with community life.

Goals may at times be quite limited. Bringing an incapacitated chairbound individual to the point where he can manage his own toilet needs, open and shut a refrigerator door, manage very simple meal preparations, and make effective efforts at intermittent self support—with others supplementing these activities—is an example. Others might be the partial control of a drinking problem in the parent of young children; or achieving acceptance in a family of regular medical or psychological treatment services. Goals may, in some instances, be established with the knowledge that neither maintenance of present levels nor improvement or recovery can be achieved; they may be directed toward gradual adaptation to decreased function, or acceptance of institutional service at a later time.

The Need for Professional Services

Those who are physically ill may have direct care needs, prescribed initially by the physician; sometimes with additions suggested by the staff as a result of assessment. Professional services, such as those for provision of medication, dressing changes, and other nursing procedures are scheduled as a part of the nursing plan. It may appear that the physical arrangement of the household is such that ambulation could be improved by use of a walker; or that physical therapy would increase the possibility that household equipment could be managed.

Direct services from professional health care personnel have their counterpart in the psychosocial status of the family or individual. There may be profound post-hospital depression, or apprehension due to the sense of inadequacy so frequently associated with major physical changes. These problems often require regular supportive interviews. Bizarre behavior in children or adults may indicate the need for psychological evaluation and support. Other professional services (nutrition, counselling, speech, physical or occupational therapy) may be scheduled as a part of service plans.

Homemaker/Home Health Aide Care Plan

The development of the care plan for general supportive homemaker/home health aide service in the home is most effective if it is viewed as supplemental to those capabilities which are either present in the family or (individual) or may be developed in time. Services are planned so that they do not discourage activities which can be undertaken by the family or patient; and the services are modified so that fluctuations in the abilities of the recipient are taken into account. Services are provided in greater vol-

ume and/or with greater frequency in periods of stress or of increased disability. They are correspondingly reduced in periods of improved function. The temptation to use this rationale to justify inappropriate planning can become very great when the agency is pressed for funds or staff time, or has rigid eligibility practices.

It may be true that a father "can" (is physically able to) do the family laundry after an eight or 10 hour work day. It may also be true that a physically handicapped housebound patient "could" ask her neighbors or a son or daughter living miles away to perform such services. People in stress "can" adjust meal times to bizarre hours (as they must in institutions), or "make the effort" to bathe themselves or go without a bath for more days than are comfortable. However, such adaptations to agency policy rarely have the effect of "strengthening family life" or "achieving rehabilitation goals," which are so frequently the publicly-stated objectives of homemaker/home health aide programs.

Homemaker/home health aide service plans realistically take into account such factors as: 1) the functional status of the individual recipient; and 2) the need for maintenance of the physical environment. For those who are ill, physical mobility is an important consideration. Careful questioning is directed to the patterns of mobility throughout the course of the day, and from day to day. The individual who lives alone or with others who are also physically limited—as with couples or families in the older age group, or young adults who must provide care for the physically handicapped—may, in a crisis, rise to the occasion and be capable of what appears to be an average or above average expenditure of energy. However, pressures, when they must be sustained unremittingly over extended periods, may become destructive of health and sanity. These same factors have considerable effect when the pressure is psychological: worry over the illness of a spouse, over the safety of children in the hands of strangers, over sudden financial problems, or severe depression or responsibility for the care of the emotionally ill.

In general, the ability to "rise above" crisis is enhanced by considerable shoring up or replenishing of physical and psychic sources of energy. Physical mobility when it is assessed for the home care plan is most effectively viewed when it takes into consideration the normal pattern of daily life and the effects of the present crisis upon that pattern. Precisely stated, such limitations will delineate the capacity of the physically limited individual in such *key* functions as toileting, getting adequate nourishment, maintaining bodily cleanliness, dressing, and maintaining an adequate physical environment.

Functional status in child care will have less to do with individual physical mobility and will place greater emphasis upon the capacity of those adults who may be available to reasonably undertake those activities which are essential to the maintenance of a normal pattern. Whether the family habitually has a family meal or is casual about meals; the routine of napping, after-school-play, and snacks; music lessons; and dental appointments—all have to do with individual and family functioning, potentially endangered by the current problem. The objective of the homemaker/home health aide plan will be to provide services which will complete habitual routines and lead to a restructuring of normal life.

In terms of the need to maintain the physical environment, if the home is to be the therapeutic environment which all home care plans envision ("serene, clean, and secure," adjectives frequently used by homemaker/home health aide programs), it must lend itself in at least a reasonable degree to the objectives of the plan.

The present state may indicate the standard of housekeeping which has prevailed, always including the consideration that present difficulties may have brought about some deterioration. A clean or a dirty house is not necessarily a factor in the projected success of the home care plan. Standards vary widely, and there have been some very happy, stable, contributing lives lived in very "relaxed" surroundings. The description of housekeeping standards in judgmental terms ("The house was unspeakably filthy"; "Mrs. S. is a very dirty housekeeper") is undesirable, since it may influence the homemaker/home health aide and turn acceptance into adverse attitudes. Objective and precise description is preferable; and mention of extenuating circumstances is important. Nevertheless the physical environment must be assessed and services planned in terms of what is to be done by the homemaker/home health aide in order to maintain that environment.

For the homemaker/home health aide, planning must take into consideration the number of rooms, condition of furniture, availability and adequacy of kitchen, food storage, toilet and bathing facilities. "Adequacy" may frequently be stretched to considerable lengths; hotel rooms have been the locale of many home care plans. Homes in which kitchen and toilet facilities are inconveniently located have been adapted. The feasibility of homemaker/home health aide service and the degree of disability of the recipient must be considered in relation to such inadequacies. Safety, basic standards of hygiene, and finally the sheer physical problems of health care and home maintenance for the homemaker/home health aide will be deciding factors.

Associated with the internal household arrangements are those

which are external but still relevant. Is laundry done in the home? Sent out? Taken out? What must be done about it? The tendency to ignore real needs ("only 'light' laundry may be done") leads to ineffectual care. It may not be possible to do heavy laundry by hand. The necessity for taking it out to the neighborhood laundromat (and the accessibility of that laundromat), or for sending it out (and financing the service), must be faced. The plan to provide adequate food supplies must be equally realistic. Where are they usually purchased? At what intervals? (And most important, how paid for?) Flights of stairs—which must be considered if the homemaker/home health aide is expected to assist an adult to go outdoors or to ambulatory medical care—are important; and the availability of transportation should be considered, as well as the possibilities for out-of-home activities (backyards, gardens, parks and recreation facilities).

FORMULATION OF THE PLAN OF CARE

Assessment of need in the context described, and of the complex of services required to meet that need, can be precisely formulated. The following will serve as one example of a well formulated plan of care.

In Health Care: Goals

1 Increase ambulation; work toward self-help with dressiig and bathing.
2 Improve nutrition; encourage participation in meal planning.
3 Work with present depression and attempt resumption of social contacts.
4 Involve adult daughter in plans.

Services:

Nursing: Visit twice a week for dressings and to help with bath at first. Homemaker/home health aide to take this over. Discuss special diet with nutritionist and homemaker/home health aide. Visits to be made around 10:00 a.m. if possible.

Social Work: Visit approximately once weekly. Try to reach adult daughter. Homemaker/home health aide to note depression; encourage her to have friends visit as they did before her illness.

Homemaker/ Home Health Aide:	Visit four hours three times a week: Monday 8–12 a.m. Wednesday 1–5 p.m. (accompany to medical appointment 1:30). Friday 1–5 p.m.
Homemaker/ Home Health Aide Activities:	Basic cleaning: kitchen, bath, patient's bedroom (priority), dust, vacuum other rooms as possible. Shopping (telephone for list before coming). Laundry to laundromat. Food: lunch and dinner each Monday, Wednesday and Friday and casserole for Tuesday and Thursday, plus puddings, salad, wrapped sandwiches for lunch Tuesday and Thursday. (See special diet). Check cashing (every two weeks). Pay utility bills once monthly at bank near supermarket. Obtain loan shopping cart from office. Thirty minutes in backyard Monday and Friday when weather is warm. Finances: limited—check with office for special needs or if there are shortages for basic needs.

In Child Care: Goals

1 Encourage father's participation in establishing more normal routines, particularly for youngest child.
2 Encourage discussion of mother's illness; reinforce assurance that she will soon be home.
3 Work toward a moderate routine of "chores" for older children to be continued on mother's return.
4 Alert school personnel and discuss daughter's school problems.
5 Plan with mother for convalescent and on-going routines in home.
6 Initiate health care for all family members.

Services:

Social Work:	Visit twice weekly; after school with children; after work with father; weekly with mother in hospital.
Public Health Nurse:	To check immunization and initiate pediatric supervision.
Homemaker/ Home Health Aide:	Daily 2–6:30 (or until father comes home).
	Food shopping en route at supermarket (milk is delivered).

Laundry—twice weekly. Sheets go out every two weeks. Washing machine available. Limited ironing. (Father's shirts—priority.)

Household maintenance—general—as possible. Older children may be encouraged to help with bath and kitchen. Father does heavy work (carpets, floors on weekends, and will bring in heavy grocery staples if homemaker/home health aide prepares list).

Wednesday: Dental appointment every two weeks at 4:15. Older boy will supervise.

Finances: Father will provide weekly food allowance. Pays all utilities.

Special problem: Check bed of six-year-old (eneuresis recently controlled; may recur). Report to social worker; do not comment to child.

Encourage participation of children in moderate household routines and in plans for mother's return. Reassure re: mother's return at every opportunity.

Describing the Planned Services

The most careful description to the family or recipient of both the service and the projected plan is important now. It is not enough to say, "We don't take over. This is your home." It is usually more effective to describe the projected service in practical terms: the professional services of the agency; the characteristics and training of the homemaker/home health aide; her duties and functions; and the possible outside resources that could be brought in to keep the home intact and protect the integrity of the individual(s) who will receive service. The *evidence* as it emerges in the described service should illustrate adherence to a policy of providing what is acceptable. Even when it is hoped that the service may bring about changes in living patterns, these cannot be imposed.

When a tentative plan is offered, the attitude of the recipient of service must be understood. Older persons may dislike the idea of having a stranger "taking over"; they may fear theft or "waste," may object to being "told what to do and how to live"; they may fear health care; or they may express none of these apprehensions but may, in apathetic misery, convey their sense of having been deprived of independent status.

Child care situations may be complicated by the presence of a

sick mother in the home, fearful of being inspected, criticized, or usurped as a key member of the family; in her absence a working father may be suspicious, feel himself reduced by his inability to manage alone, concerned about the effects of the intrusion of strangers on his way of life and that of the family.

Children, feeling themselves deprived of what they know—and even when it seems undesirable, the familiar is always important —may fear their sudden change of status, and the shift in relationships from their own affectional channels to dependence upon strangers.

The word "stranger" in relation to human living patterns is a very important one, particularly in times of crisis. Discussion of the plan with the recipient(s) may produce a response which will give some idea of its acceptability. Usually it will be most acceptable if it is presented as a set of services to be provided "as needed" or better still "as wanted," rather than as a summary of the activities of a brisk, well-martialled army which will suddenly descend upon an established way of life.

"I should like to come in and change these dressings and make you more comfortable. Do you think that might be easier for you in the morning or the afternoon?" is easier than "The doctor wants the dressings changed. I'll schedule it for nine o'clock."

"Are you feeling a bit let down now that you're home from the hospital? I'd like to come by anyway just to see how things are going and we might see if we could ease things. Sometimes it helps to have another person outside the family to talk to. Do you have a special time when you'd like a visitor?" is easier than "You seem to have some problems about your recent hospitalization. It will be better for you to talk them out. I'd like to schedule regular interviews on Monday, when I'm in the neighborhood anyway."

It might be said in rebuttal (or protest) that it's not always possible to "schedule as needed—or wanted," professional time being in short supply. Yet such an approach is the core of successful home care planning. If it cannot be managed, the services must be prepared for a high percentage of failures. We are *in the home.* Institutional approaches do not work well there. In institutions, all individuals, both adults and children, enter an environment in which the relinquishment of personal rights and privileges is, to some extent, implicit. They may suffer from this; yet it is a part of the meaning of "institutionalization." Such circumscription in the home, which might be considered an extension of the person, becomes a far more destructive experience; the maintenance of the extension *intact* is an overriding goal of home care.

In addition to the discussion with the recipient(s) of the plan for direct professional care services, the professional role as *super-*

visor of the plan is established. This is frequently misunderstood. Families often wonder why they are receiving visits from the nurse and/or social worker "when I don't need any nursing," or "she just seems to stop by to chat for a few minutes. Why?" The fact that the homemaker/home health aide is responsible to professional staff is important. The "openness" of the situation should be stressed. If the family understands that both the homemaker/home health aide and professional are prepared for frank discussion of both the plan and the services, there will be no concern about the problem of "tale-bearing." Neither the service plan nor the homemaker/home health aide status will be jeopardized. Complaints, if there are any, requests for decreased (or increased) service, or for changes in service or homemaker/home health aides are expected, and treated in a matter-of-fact way. Changes in status and relationship result from individual differences. These are considered a part of normal living.

"The Fee": Family Finances

Except in the ideal situation, both the assessment of need and the plan for care will take into account family finances. Many professionals dislike and avoid all discussions of money. Current trends in public and private agencies separate "financial eligibility" from "services," and different personnel are designated to deal with each separately. Homemaker/home health aide agencies may make this distinction as well. Many of them designate the social worker as the appropriate person to establish the fee for service, although family anxiety at worst, or curiosity at best, usually places the question "What does it cost?" early in all discussions of home care.

The discussion of the family's finances will be most productive if the atmosphere is objective and without the element of judgment concerning family patterns in money management. Agency costs are frankly discussed. Charges in most well established agencies are based upon the family's *present* financial ability, and this fact is carefully explained. When the reimbursement plan (if any) is discussed as a joint problem to be worked out, with flexibility in the event of future emergencies, the question of reimbursement is placed in the normal perspective of other family financing of needed supplies and services. The financial plan does not become a cause for gratitude, anxiety or shame.

A home care plan is manifestly impossible if there is no money for food, if funds are so limited that a necessary broom, mop, shopping cart, or laundry fee cannot be provided either by the family or through the efforts of the homemaker/home health aide agency; or if utilities are not available, such as a telephone, which

is necessary for safety. Attention to basic financial need in the family will necessarily have priority in planning services.

THE FUNCTIONING PLAN OF CARE

When the care plan has been formulated and accepted, its initiation and maintenance will involve a number of elements. These include coordination and leadership within the service agency and in the utilization of "outside" resources; the selection, placement and supervision of the homemaker/home health aide; maintenance of continuity of service; reassessment and, where necessary, adaptation of goals and services.

Coordination and Leadership

Coordination in the maintenance of the plan, whether it is expressed or tacitly understood, is usually described as a form of "team work." In homemaker/home health aide services the team is seen as a triangle made up of the professional staff, the homemaker/home health aide and, in health care, the physician, who is usually understood to occupy the apex of this triangle. With the steady decrease in home visits by physicians, and their presence at staff conferences, physician participation may be limited to a telephone call or a set of written orders. Nevertheless, if every possible channel of communication is kept open and the medical treatment plan is well understood and interpreted in exactly the same way by all participants in the plan, the unanimity of purpose and function that are essential to coordinated effort is usually achieved. Where psychiatric or psychological leadership is involved, there is a danger of imprecise interpretation of plans. The correction here can only be obtained through a channel of continuous communication with that leadership, by whatever means is possible.

Within the home care staff, when there are several disciplines involved in providing care, an explicit determination of leadership may be made. This may be based upon the primary presenting problem or upon the probability that one member will have the strongest relationship with the family; or it may be because of greater availability of a staff member. Leadership responsibility in a given plan does not necessarily involve its direction. It is, rather, a mutual agreement that the activities of all members of the group will be coordinated and most important, that those parts of the plan which must be implemented by the homemaker/home health aide are consistent. Many programs rely on written records for coordination. They are usually available after the fact. Less formal approaches—brief notes or a quick daily verbal

review of all cases in which there have been significant change—are often effective; and effectiveness is enhanced when built upon interdisciplinary good will and a joint professional appreciation of the homemaker/home health aide.

The case conference is a standard tool in the maintenance of coordinated effort. It is a good one, provided it does not become a mechanical chore imposed as a routine requirement. The avoidance of rote review is difficult to manage. The principle that every plan will be reviewed at reasonable intervals—with frequent reviews in those instances considered "at risk," and with the understanding that a conference may be requested by any member of the group (including the homemaker/home health aide) at any time—is one method of insuring a more vital approach. However, most agencies find routine review easier to manage. It is a method which requires less judgment and may be desirable when staff is less experienced.

Involvement of Outside Resources

Participation of staff from sources outside the group and outside the service program itself may present problems in coordination; yet maximum utilization of community resources is an important component in quality service. In smaller communities, where resources are limited, interagency and interdisciplinary relationships may be almost as informal as those within the team. In larger urban or very large metropolitan areas, where the range of public and private resources may be wide and the multiplicity of eligibility requirements varied and confusing, it may be difficult to sort out what may and what may not be available. It may be even more difficult to draw these services into the home care plan in an orderly and coordinated way.

The tendency to focus exclusively on the agency's own services, ignoring or leaving to indeterminate "others" the task of doing anything that is "not our function," is natural. While it is unreasonable to expect a home care program to take on the responsibilities necessary to meet all of the needs that may be present in the household, those which bear upon the success of the plan of care demand attention and effective action. The resources in the community which are involved must be familiar with the homemaker/home health aide program, must have confidence in its staff, and respect its policies. Familiarity and respect do not usually develop spontaneously; they are the result of mutual effort.

Services Most Frequently Helpful

The services that might most frequently be required are those that provide medical care, related health services, and services

that supplement the plan. Those who are involved in providing these services are physicians who, because of the character of their practice, have a consistent interest in in-home services. Physicians whose patients are in the older age group, those whose interest is in physical restoration, or who act as pediatric or psychiatric consultants, are apt to be comfortable sharing information and be more understanding in their response to agency needs. Other health resources include ambulatory services such as clinics and health centers; the preventive and treatment programs of the health department, particularly those related to health supervision, communicable disease, and environmental sanitation; certain voluntary resources such as rehabilitation centers or mobile physical therapy services; or agencies which provide equipment and/or transportation for the physically handicapped, or those which have special interests in disease categories such as heart disease or cancer or arthritis. There may also be specialized community services for the handicapped, such as the blind or those with hearing handicaps. Public and private resources for the care of the emotionally disturbed include mental health centers, psychiatric clinics, and child development or specialized day care centers. In the field of social health, the special services of public agencies (child welfare) and of private agencies such as Family Service Associations, are usually available. In all of these, familiarity with what can be provided and the circumstances under which referrals may be made can make a very great difference to the individual care plan.

Where financial difficulties affect the home care plan, solutions are usually hard to find and may be aggravated by the fact that the various eligibility requirements of both public and private sources of financial assistance are complicated and occasionally appear irrational in terms of human need. Financial pressures and worry about money are destructive to those who are ill; knowledgeable and unprejudiced assistance can make the difference between the success and failure of the care plan.

When supplementary services and assistance are brought into the plan, the need for coordination is increased in proportion to the number of new and different points of view introduced. Although much emphasis is verbally placed upon the inclusion of all involved services in the planning process, except in fairly complex or acute situations it is not always possible to arrange for full participation of personnel outside the homemaker/home health aide program in regular joint conferences. It is, however, possible and important to maintain a regular exchange of information so that understanding of the plan and activities related to care are in harmony with agreed upon objectives.

Selection and Preparation of Homemaker/Home Health Aides

Ideally, the homemaker/home health aide selected to implement the home care plan should "match" the situation in which she is placed. Aides who have been properly recruited, trained and supervised will, as a matter of course, share common characteristics: those of tolerance, warmth, and adaptability; and will posses the essential knowledge and skills to meet most service requirements. Nevertheless, in any group of homemaker/home health aides, there is a wide variety of aptitudes based on natural temperamental and personal differences. If it is possible to avoid the placement of a talkative aide where silence is appreciated, the plan will be enhanced. Or, it will be enhanced if a very good cook is placed where nutrition is the problem (and not all homemaker/home health aides are *very* good cooks); or if an aide who is partial to young children is placed where the children *are* young and probably very anxious.

Occasionally, schedule shifts may be made to bring just the right homemaker/home health aide into the home which most needs her services. Such shifts are very readily accepted by some families, but might be difficult, if not destructive, in others. Whether or not it is possible to make a good "match," careful preparation of the aide for every new assignment is important. First, she must understand something about the individual members of the family so that her services are always provided to individuals. The assignment which starts with a remark to the aide such as: "I'm going to send you to an alcoholic case"; or, "You'll be taking care of a bad heart patient next week," affects the attitude of the aide. The natural response of most human beings is to view others in human terms. Homemaker/home health aides usually have this characteristic in good supply and it is this, more than almost any other quality or skill, which provides the essential support in home care plans. In making the assignment, therefore, all of the observations which will help the aide to see the person behind the symptoms will give her the assurance she needs to enter and sustain each new plan.

Additionally, the specifics of the plan as they affect her activities are important; perhaps more important than diagnostic terminology. She must know what she is expected to do and what the individuals in the family are to do. "General cleaning" is open to interpretation. It is better to say: "Do the bathroom the first day, if you can. It's been neglected. Then see if you can start a regular routine, one room at a time." Or: "She's not interested in food at all. See if you can get good meals for her. That's the first priority. She misses her baths, too. Those come next. And if you don't have time to keep things going and go walking

with her, let me know." Experienced homemaker/home health aides know the short cuts and can frequently make swift estimates about the amount of time needed for various tasks.

It is important to ask for reactions to the plan after the first few days. If economies which result from these judgments are used *to enrich the plan,* that is, to give the aide more time for a relaxed approach to the personal needs of those in the household, she will be more apt to make them. Pressures to economize on her time and energy in order to squeeze the last drop of use from her services will ultimately make for a poor and unwilling aide. In establishing treatment goals with the aide, these should be described *as they affect her activities.* Human terms will always bring better results than depersonalized comments.

Good selection of the homemaker/home health aide, a description in human terms of the people she is to help, preparation of a list of her activities and those of others, and the establishment of certain "key" activities or attitudes which move treatment goals forward—these are routine elements in establishing the homemaker/home health aide plan.

Supervision of the Homemaker/Home Health Aide

Since the agency is to take responsibility for the activities of the aide, it must assure itself that those who will be providing training and/or direct supervision have adequate time to give to the aide. There must be a sense of priority so that staff will not set aside the needs of the aide in favor of what might seem at the time to be more pressing or important responsibilities. Here the professional worker will find that a new pattern of response must be established in the supervisory relationship.

Supervision of the aide is less a matter of setting up a chain of command in which one individual (the supervisor) gives the orders and another (the aide) takes orders, than it is a joint enterprise—one which is mutually instructive in its interaction and in its objectives. The relationship of supervisor to hospital aide in an institution, which is so frequently used as a parallel illustration, does not really apply in homemaker/home health aide service. The institutional setting provides for a continuous contact between supervisor and aide so that the mechanisms and the minutiae of order-giving and order-taking can be established. This continuity of command and observation is not possible in the home. The supervisor must rely upon the homemaker/home health aide to function effectively away from the continuing observation of the professional. Exercise of independent judgment, the ability to respond to crisis, self-reliance and skill in the performance of personal care and other tasks are required of the aide; these

capabilities cannot be developed in the order-giving order-taking frame of reference.

The motivation for internalized standard-setting, which is usually attributed to the professional who understands the necessity for following through scrupulously and repetitively in order to achieve optimum results, must be established in the homemaker/home health aide. Although aptitude, which is discovered in the selection process, and the essential knowledge and skills, which are acquired in the training process, are essentials, they will not in themselves guarantee continuity of high quality homemaker/home health aide performance.

The reluctance of many homemaker/home health aide agencies to train aides to perform any but the most routine tasks is usually based on the apprehension that non-professionals cannot be trusted to undertake these activities unless a professional supervisor is present at all times. Many home health agencies, in the developmental phases of their homemaker/home health aide services, found that nurses were spending approximately as much time supervising the giving of the bath as they might if they gave it themselves and that, in place of providing an extension of nursing capability, they were sending two people to do the work of one. Social workers, at first, found themselves cautioning the homemaker/home health aide, fearing that the "opening-up" of certain emotional problems by an unskilled (and perhaps uncontrolled) non-professional would compound, rather than relieve, existing difficulties. Physical therapists and, to a lesser extent, occupational therapists, express the same fears at times. Perhaps the nutritionist, whose whole approach is an educational one, is least worried about potential problems when homemaker/home health aides accept increased responsibility for services which are closer to those of the professional.

These apprehensions are understandable and it is not very helpful to remind professional staff that they have worked with aides (or at least seen them work) effectively in institutional settings. It is equally unproductive to cite these activities as "the kinds of things relatives and friends do for others every day." Nor do accusations about professional possessiveness with respect to certain areas of competence bring positive results. When, in fact, the ultimate responsibility for the home care plan rests with the professional (as it does), and when the professional must rely upon another person for its partial implementation (as she must, when placement of a homemaker/home health aide has been made), some genuine professional concern is understandable. The channeling of that concern in order to produce quality in care is the most effective way to alleviate it.

It cannot be assumed that every homemaker/home health aide is equally adept. When we refer to "matching," this must apply as well to certain skills. It is the responsibility of the professional to determine what the level of care in the home will be. It is also her *responsibility to decide whether or not, in a given situation,* the homemaker/home health aide is capable of performing skillfully. Many home care plans require constant change and adaptation of tasks and services, some of them increasing in difficulty and complexity. Professional supervision involves the exercise of judgment as to who shall perform these tasks, and under what circumstances. If the relationship between the aide and the professional staff is a good one, the aide herself will express her opinions about her own capacities in given situations.

Professional unwillingness to accept the potential role of the aide may at times be masked by a consistent reluctance to assign responsibility to her or help her increase her capabilities. The first bed bath in the home may be awkward; the first depressed or irritable adult may be discouraging; the first group of frightened, recalcitrant children may be exasperating. The total willingness of the professional to be leaned on, used, and questioned; her constant and watchful approach to signs of uncertainty, insecurity, or timidity in the aide as she takes up her assignment; the suggestions and reminders of learned knowledge and skill; and the explanations which will increase insight—these are the distinctive elements of "supervision" as they apply to the homemaker/home health aide in the continuing plan. They are called upon in varying amounts and degrees with each new assignment. The supervisor who cannot accept the requirement that the homemaker/home health aide will need more than "orders" will miss the rewards which come from seeing goals achieved through an extension of her own capacities to those of another person.

A "good" relationship between homemaker/home health aide and professional (and they do almost invariably exist in established programs) is precisely one in which the order-giving "supervisorial" role has been replaced by a clear understanding of mutual roles and mutual goals. If the aide does in fact understand that physician, nurse, social worker, physical therapist and all other members of the home care staff are valuable because of their knowledge; and if she trusts the professional members of the treatment group to help her know why selected services are being provided and how they are to be effectively provided, she will have been helped to the first level of a "good" relationship. If on-going care becomes a joint effort in which she sees that there is sensible planning of her role and in which she plays an active part, this will be another level in that relationship. Emerging from these is the recognition of her own unique value.

More often than not, because she is not a professional, there is an openness and a naturalness in family attitudes toward her which provide entree into the home situation. Because she is more continuously present in the home than any member of the professional staff, she is often in a better position to report changes in the physical state and the emotional climate. She may notice minor changes which may have great significance. Here "supervision" has its greatest effect if she has been taught to value her own instinctive responses and observations, and if these are heard thoughtfully and with comprehension. Recognition of the therapeutic use of her own personality in the home is of the greatest importance. This is perhaps a portentous sounding concept, but it has been remarked upon repeatedly in those programs which do not smother the innate capabilities of the aide. Because she is natural in her response, her ability to *feel* the physical or psychological discomfort of others is perhaps more acute. Her own strength and the positiveness of her hopes are of inestimable value (as long as sympathy and hope do not escape into unusual channels).

It is common in most professional services to structure supervision in such a way that there are set times for conferences with the aides and established patterns of "reporting in" at regular intervals. Ordinarily, except in emergencies, staff will be sufficiently organized to use this time for supervisory help. Structured supervision of this kind will also be desirable in working with the aides on those aspects of supervision and training which are best handled in such an organized fashion. This, however, cannot be the only access the aide has to her supervisor. From the outset, she must be assured that her supervisor will be available at any time to answer any question, to repeat directions or instructions, and to give support. She must be assured that there will be a willing and understanding person available to discuss the slightest insecurity.

The certainty that the supervisor or a responsible staff member will be immediately available plays an important part in the development of security and self-reliance. There must be an atmosphere of approval when the aide turns to the supervisor so that she does not at any time feel that what she is asking is unimportant, inconvenient or unprofessional. An accepting response is particularly necessary in the initial stages of training and employment, when the aide may be uncertain as to what is important and what might be overlooked. The supervisor must establish clearly that she will take immediate responsibility for emergencies; when errors in judgment or practice do occur, these must be dealt with by the supervisor patiently and without reproach or recrimination. The aide must never become fearful

about reporting to the supervisor her own errors or misunderstandings. When they occur, they should be dealt with in terms of the immediate situation, and at a later time may be used either in training or conferences to assist the aide in meeting such situations differently another time. While this may seem a very uneconomical investment of professional time at the outset, it will more quickly develop security, independent judgment and the aide's ability to distinguish those observations and situations which must immediately be reported from those which may wait for scheduled discussion.

Support when the inevitable disappointments and sorrows come to the homemaker/home health aide as she works in the close environment of the home is most constructive when it is directed at enlarging her viewpoint. Her conception of her role as a helping one *whatever the circumstances* is more apt to achieve this than the "how do you *feel* about death?" approach (although discussions which increase insight are often very helpful in the training program). The supervisor is an enabler. The skill with which the personality of the aide is directed as a therapeutic element in the home care plan is one which demands thought, sensitivity to the atmosphere in which relationships grow, and considerable wisdom about the natural history of such relationships.

Continuity

Continuity in the care plan is expressed in the establishment of a channel of genuine communication with each family under care. It is expressed in regular professional visits which provide specific services, but which look beyond these for a positive and increasing understanding of patterns of living, emerging needs, and characteristics of the relationships set up by "the plan" as they affect its quality. "Physical" continuity—the continuous presence of the homemaker/home health aide in the home as scheduled—is of the greatest importance. Each household must be secure in the knowledge that the promised service is reliable. The aide arrives exactly when she is expected, stays for a planned period of time, and departs as scheduled. Many homemaker/home health aide programs provide both the family and the aide with a written "schedule" which outlines the hours, days and general activities in the support plan.

Changes are made only when planned and there is never manipulation within the household or by the aide to change to something which appears momentarily more desirable. When the aide is ill, or must be absent for other reasons, substitution is made and is explained in advance of the arrival of the substitute. The assumption that the recipient of service will not "mind" who

appears as long as the service is provided is inaccurate. Children frequently have real difficulty, particularly in times of crisis, when the presence of the aide, not just any homemaker/home health aide but *their* homemaker/home health aide, cannot be relied upon. Adults, whether they are young adults or "elderly," have great difficulty accepting arbitrary change in times of illness or stress. Experienced staff will soon become familiar with frequent refusal to accept a substitute, and this is usually a refusal which is rooted in feelings of being "pushed around" or "not considered" rather than in any real dislike for the substitute.

Continuity includes the delivery of those specific services outlined in the plan *as planned*, rather than sporadically. Regular professional attention to the homemaker/home health aide in the performance of sometimes unrewarding routines of bathing, dressing, shopping, cooking and cleaning; and searching professional interest in her reactions and observations enlarge her capability when she is helped to understand what has happened, to notice particular events; or when a different approach to planning a salt-free meal or dealing with a passing depression are taught.

Reassessment and Changing Goals

Regular reassessment of each plan will increase its effectiveness. Acute or complex situations do, naturally, attract frequent attention. The long-term plan which appears to be going along "as usual" tends to be forgotten and may be slowly deteriorating. The homemaker/home health aide may take her cue from professional staff and lose the vigor of her approach and her enthusiasm for maximum restoration even in the minimal or "chronic" situation. When obvious deterioration is occurring, reevaluation based upon the need for a fresh approach may produce improvement, and the aide will feel the impact of a concerted effort in which she participates.

Certain diagnostic groups or specific types of problems may be identified by the agency for reassessment. These may be home care plans which were accepted for trial periods; they may be plans in which transition to institutional care is anticipated, or in which deterioration is expected. Reassessment can at times become the setting for a general ventilation of unfocused reaction, dissatisfaction and complaint. The "unresponsive" plan—that is, one which does not produce results on schedule—can breed a good deal of frustration; and frustration tends to be both circular and contagious. When the contagion spreads to the homemaker/home health aide and she begins to talk about the "uncooperative," the "dependent," the "unmotivated," and the "manipulative" individuals who do not react or who do not progress as planned,

one of the immediate essentials in plan change will be replacement of that homemaker/home health aide with another who is not infected.

Valid reassessment is carefully focused. It probably involves a backward look: "What did we know when we started and why did we plan it this way?" And it involves a new projection into the future: "Are our treatment goals the same and are our methods to be the same or different?"

Over the period of service, goals may change. Such changes are often surprising; what seemed a poor outlook may become a far more optimistic one. Early hopes may not be realized—in such instances, rigid adherence to an initial plan becomes a barrier to good service. Estimates by those most intimately connected with the regular provision of services and willing to try a new approach are important in establishing the need for change.

Termination of Service

Programs which by policy limit the duration of service have problems when the need does not "terminate" in the specified period of time. This may place the service staff in a difficult position, one in which they may either rationalize the situation to fit the policy or communicate a sense of defeat and frustration to the recipient and the community. Despite great care at intake, which may limit acceptance only to situations which will be appropriately short-term, unforeseen eventualities do arise which make arbitrary termination very difficult. Some flexibility in the application of such a policy is desirable. Alternative methods of care may be explored; and staff responsibility in following through on referrals to supplementary care should be emphasized.

When termination is based upon need, the responsibility for termination will always involve a joint decision, made either because the plan objectives have been achieved or because the service is no longer appropriate. In the latter case, a more appropriate plan developed by the staff will, to the extent that it is possible, be implemented by means of referral, the transmission of information to referral sources, and follow-up to assure a satisfactory outcome of the referral. Termination because of "uncooperative" attitudes, or because the need for specific elements in the plan ("personal care is no longer needed") has diminished should be carefully evaluated in terms of over-all plan objectives.

When there has been a decision to terminate service, the recipient and/or family will accept termination or an alternative plan if there has been careful preparation for the change and

if there is understanding of the nature of the alternate plan and the hoped for objectives which will result from the change. In many programs termination is accompanied by the assurance that service will be reinstituted should the need arise again and occasional follow-up calls to review current status after care has terminated are a source of reassurance.

CHAPTER 8

Recruitment and Selection of Homemaker/Home Health Aides

The formulation of agency standards which identify the qualities and characteristics of acceptable applicants for homemaker/home health aide training and employment will simplify recruitment. Well defined standards avoid confusion and disappointment for unqualified applicants who may be referred to the agency, and eliminate unnecessary and time consuming interviews by the staff. When the community understands the requirements for homemaker/home health aides, there is an inevitable enlargement of understanding of the services; recruitment standards are therefore an important component in the program of community relations.

Recruitment efforts are most successful—particularly in a new service—when the duties and responsibilities of the homemaker/home health aide are clearly defined. Essential requirements for applicants may be stated as follows:

Homemaker/home health aides must perform effectively in a wide variety of situations. Effective performance requires unusual flexibility, and the ability to adapt.

Homemaker/home health aides are invariably assigned to situations in which there is considerable stress: physical, emotional, and economic. The reaction to stress is individual and frequently extreme. The homemaker/home health aide must have the capacity for acceptance of behavior under stress, understanding, and objectivity combined with warmth.

Homemaker/home health aides usually have multiple assignments. They may provide services to three or even five different families in the course of a single week. They must be capable of moving easily from family to family, performing in each in accordance with differing treatment plans. They must be well organized, stable, and not easily upset by sudden changes or unusual demands.

Homemaker/home health aides provide a wide variety of services, many of them physically demanding. They must

have the physical stamina for continuous, rather than sporadic performance.

Homemaker/home health aides must be careful observers. They cannot function effectively if they blindly follow instructions, without relating these to results. They must have the capacity to be interested, observant, and distinguish between regular and uncommon occurrences.

Homemaker/home health aides must make use of supervision intelligently. The capacity to accept and follow direction, and the desire to increase their knowledge and skill, is important. They must be capable of independent judgment that distinguishes between taking over and taking safe, sensible action in unusual situations.

Homemaker/home health aides must be contributors to the service: a healthy desire for employment as employment (as opposed to "doing good") is a part of this. Equally important is the capacity for a strong identification with the goals of the service; interest in suggesting ways to increase the effectiveness of individual treatment plans; and interest in participating as a full team member in the process of assessment, care, and use of the community.

Sources for Recruitment

Questions arise when homemaker/home health aide services are planned in a community which has not offered them before. Where are "good," "reliable" or "skilled" homemaker/home health aides to be found? What are the best sources for recruitment? How is the quality of applicants determined?

These questions may be answered simply: "Good" homemaker/home health aides are not "found"; they are "made" through a process which begins with the establishment of standards for selection and proceeds through carefully designed and continuous training. Well planned, supervised practice which increases in complexity with increased skill is a part of this training. The term "trainee," which is used in the selection process, places the applicant in her initial role. The trainee is selected because of important personal characteristics; the "good" homemaker/home health aide is one who, because of these characteristics, makes use of training to increase her capacity to provide helping services with warmth, skill and judgment.

Occasionally, in specialized situations, recruitment devices are used. These are fairly traditional: employment services, newspapers, clubs, church groups and similar sources. In general, however, the experience has been that following the first announcement that such a program is contemplated there is an

almost unlimited supply of applicants for employment. The word *employment* is what is important.

Once the service has been established, employed homemaker/home health aides themselves may be the most effective recruiters. Interested, satisfied employees can help recruit others, as they know what the work involves and requires. They will usually be able to stimulate interest among friends who have similar interest and capabilities.

SCREENING AND SELECTION OF AIDES

The criteria for selection of potential homemaker/home health aides are relatively simple when one considers the services which are to be provided by the program and the needs of those who will be receiving services. If there is confusion about such criteria, it will usually occur when standards for selection are affected by considerations other than service needs.

The primary intention of the selection process is to recruit potentially excellent homemaker/home health aides. If this objective is shifted to a lower priority in order to provide employment with less concern for the personal qualities of the recruit, there is a possibility that neither a quality service nor a possible employment resource will be achieved. Selection, therefore, cannot be designed primarily to provide employment to any specific group—neither the economically needy, nor a particular age group, nor a particular cultural group. It may *incidentally* provide employment to some members of all of these groups—and probably will, since recruitment for employment normally takes place among those who are unemployed, underemployed or lack a set of skills specifically adaptable to current demands in the labor market.

The emphasis upon recruiting recipients of public assistance and other disadvantaged persons in the community is understandable. Both the disadvantaged and the community have a valid interest in substituting a reasonable employment pattern for the frequently destructive experience of dependence upon subsistence allowances. In the selection of homemaker/home health aide trainees, however, this interest must be weighed against the realities in individual situations.

Women with Young Children

Women with young children cannot usually be expected to assume the responsibilities of a homemaker/home health aide. Their first concern will understandably be for their own children. The demands of their own households, the need to care for their chil-

dren during periods of illness, and personal difficulties posed by sudden changes in assignments weigh heavily upon them. It is questionable whether the best interests of the community will ultimately be served by pressing this type of training and employment upon mothers of young children.

This is not to say that certain women receiving public assistance or with limited incomes cannot be trained to become effective homemaker/home health aides, even though they have children. Those who are genuinely interested in such employment, whose children are of an age that they can be safely left alone, or for whom responsible child care plans can be made, bring a good deal of experience, understanding and skill to this work.

The Older Worker

The strong interest in providing employment for the older worker is also understandable. Much has been said or written about the effects of limited employment opportunities on those who have passed the peak years. They, too, must be viewed in realistic individual terms when it comes to selection. Employment as homemaker/home health aides will be feasible only if the older person can handle the considerable and unremitting physical pressures of the work. It is unrealistic to encourage training and employment on the basis that work as a homemaker/home health aide will supply the older person with "something to do," or in order to solve personal problems of loneliness and lack of direction.

Older workers have functioned very effectively as homemaker/home health aides. Many of them are women who have never been employed except in their own homes. Some seek employment because they no longer have a source of support, others because their families have grown and they dislike the relative inactivity which has come about because of absence of accustomed responsibility. They function well, however, *only when they possess the special aptitudes required* for the work.

The Very Young Adult

Employment of the very young adult, who has appeared to be either without purpose, misplaced in previous employment, or so unskilled that employment resources are totally absent, must also be considered with care during the screening process. Homemaker/home health aide employment has provided a vital interest for many of these young adults, and has indeed opened up channels into more specialized training in fields which had not been considered before. The overriding consideration, however, is not the need for purposeful employment—it is the potential capability of the individual trainee. The capacity for, or the

presence of, an ability to conform to routines, to accept direction, and to develop stability and an essential maturity of emotional response are as important in this group as in all of the others.

In general, it can be said that no particular "group" can be delineated as the best able to provide the needed services. The recruitment resource will be the available, unemployed population, usually unskilled. From that population, imagination and flexibility in selection will produce trainees and workers who can provide services of high quality, provided the framework in both training and service are well planned.

THE PROCESS OF SCREENING AND EVALUATION

Methods of screening applicants for training and employment as homemaker/home health aides are varied. The screening may be undertaken by the employing agency, by an employment service, or by a school which has been established for the purpose of training. Community agencies, both public and private, may select or refer families or individuals receiving agency services as possible trainees. However, those who make the *selection* of trainees must be closely involved with the purposes of the service to be provided. If the principle that employment opportunities must realistically exist is firmly established, it is important that representatives of the employing agency take an active part in selecting potential employees when the training is to be undertaken outside the agency. In these cases, perhaps the most effective plans have been those in which agency representatives set the number of trainees they will employ and supplement the screening process with interviews. Or, to be even more effective, they can interview and employ the applicant *prior* to training.

Employment for a brief period prior to training is for purposes of orientation and helps to determine which applicants are best suited to the purposes of the service. This practice has the desirable effect of supporting the interest of the trainee throughout training and of eliminating the discouraging and frustrating experience which results from training large groups of applicants who, in the process, are discovered to be clearly unsuitable for the work which is to be done.

The selection process will differ considerably from conventional employment practice. In conventional applications, most of the burden is placed upon the applicant. She comes seeking employment and is expected to provide evidence that she is capable of performing the available work. This presupposes knowledge about the work and forces her to focus her self-knowledge concerning

her aptitudes and skills. Usually, though not always, the conventional employment application involves a written document in which the applicant provides information about herself, her work history, and those references which attest to her ability. This, too, involves skill in selecting and emphasizing her experiences.

The process of selecting trainees for in-home services will be most productive if these conventional methods are forgotten and major emphasis is placed upon assessing each applicant's potential with respect to attitudes, personality, and the ability to learn and use what is taught. It is often effective initially to ignore the written application. Instead, an arrangement in which, through one or more interviews (and if necessary with different interviewers) the applicant is helped to describe herself will be much more productive.

Focus of the Interview

First it must be understood that the unskilled and frequently completely inexperienced applicant will not approach the application process with a high degree of confidence. The interviewer must therefore recognize that the lack of ability to present information articulately does not have a high correlation with intelligence and potential ability. To open an interview with the question, "Will you tell me why you are interested in becoming a homemaker/home health aide?" may sometimes produce interesting results; but the interviewer should not be surprised if it leads into a morass of misunderstanding and misconception.

The purpose of the employment, the nature of the training, and the prospects for the future may be unclear to the applicant initially. The words "agency" and "program" may be relatively meaningless; and the anxiety to produce the right answer when the content and purpose of the questions are not understood may mislead the interviewer. It is more productive to begin by explaining the nature of the work in simple terms, outlining the training program, and, describing the prospects for and conditions of employment. Although the applicant may still not be able to select past experiences that relate specifically to her ability to do this work, the interviewer need not necessarily be concerned with this lack of focus. The major interest will be the way in which the discussion reveals the temperament, life experience and attitudes of the applicant. Frequently, if there is no employment history, it is helpful to discover what activities that have been undertaken have been the most successful and of greatest interest, and the reasons for such interest.

When there is an employment history, the approach is the same. The interviewer will bear in mind that hesitation in discussing

past employment may have less to do with capability than it has to do with a desire to produce a response that will lead to employment. The atmosphere of the interview must be sufficiently relaxed so that the applicant does feel free, finally, to admit to certain preferences and biases. If, for example, it is made clear that a preference for working with certain age groups will not be a bar to employment—since such interest can be expanded—the discussion may then lead naturally into other areas of preference, interest, or latent skills. If, during the interview, a written application is to be made out, it is often productive for the interviewer to complete the application using each item as a focus for discussion in order to bring out comfortably those aspects of the applicant's life experience and attitudes which can be used to assess fitness for the work.

Objective criteria of fitness will, of course, be determined by the nature of the agency, the nature of the community, and the projected training and service program. Some of the considerations with respect to these will also bear a somewhat different relationship to the application process than is usual in conventional employment situations.

"Maturity"

Most programs define their expectations with the phrase: "The homemaker/home health aide must be a mature woman capable of assuming responsibility and flexible in adapting to various situations." While this may seem to imply a chronological state, experience will demonstrate that chronological maturity is not always a guarantee of the ability to adapt flexibly and assume responsibility.

The 23-year old applicant who says: "I never understood this funny talk about old people. My grandmother got old but she was always just like herself except she couldn't move around so much and then she did get sort of like a little girl, but she was darling," is more apt to do well than an older person who expresses apprehension about senility and is concerned as to whether "heavy lifting" will be involved in the care of older patients. Similarly, a 21-year old girl who has raised a family of brothers and sisters and will admit to occasional impatience and resentment but speaks with pride of some of their achievements, will be more knowledgeable than an older woman who remarks non-specifically that she has "always loved children."

Physical and emotional maturity are essential, but chronological age has less to do with performance than stability of temperament and good health. All myths about age should be avoided, i.e., that the "grandmotherly person" fills a need for young children (she

may if she likes and understands children and is physically up to the care of children and of a household) ; that very young persons fill a need for an older sister or brother (they may if they understand children and are not competitive because of their own problems concerning family place, and are capable of accepting responsibility) ; and that older people need help from a very mature (if somewhat enfeebled) individual who may serve as a "companion" for someone similarly afflicted.

Where the program can provide employment for a large number of applicants, it is often possible to consider certain special aptitudes even though the whole range of services may not be undertaken by a given applicant. In such instances, a warm responsive older trainee or a likeable eager youngster may be employed for special situations. In general, however, prospective employees should know that the work is physically demanding and that adjustment to different circumstances will be an important part of it.

Sex

Homemaker/aide services have been almost exclusively associated with women. This has been true partly because of the limited employment opportunities, and partly because of the predominance of women in the adult group to be served (about two-thirds of the group requiring services have been women living alone) ; child care and household maintenance also have been an important part of the services provided by established agencies. However, there has always been an unmet demand for men in this field. A good deal of institutionalization of men with chronic illness and disability has undoubtedly been unnecessary. Many of them might well have been taken care of at home if trained personnel had been available.

The trained male aide who can undertake the personal care of the adult male patient when a wife or other family member can no longer provide this service has not been available for service in the home. The disabled young adult and even the severely handicapped child who requires considerable assistance have often been forced to accept poor planning because activities involving lifting, the use of heavy braces and equipment, and important assistance in getting out of the house require someone with sufficient strength to perform these tasks.

In general, assistance with transportation (with its associated lifting and transfer of patients), movement up and down stairs, transfer from house to car, help with wheelchair outings, and help with some of the heavier home maintenance work offer a variety of opportunities for men—provided adequate payment and

status go with them. The observation that the type of employment offered to men is not always appealing really is not true: many men have found productive employment as institutional orderlies, and have maintained a receptive attitude toward this as a work situation.

If the employment offered is appropriate, decently paid, and has continuity, the conventions about the feminine aspects of cooking and personal care are no more valid here than they are for men who go into restaurant and institutional work. The real difficulty is, as always, a financial one. It can only be resolved by establishing a rate of pay that will open up job opportunities in home care for men by providing reasonable financial return.

Here too, however, the interviewer will have the same responsibility for exploring attitudes and for determining whether the applicant has the potential for working responsibly in the kinds of work situations contemplated by the program.

Educational Background

There is a danger that programs employing non-professional personnel for the first time may tend to equate education with intelligence. The requirement that the applicant for training and employment as a homemaker/home health aide must have completed at least a given number of school grades is commonly considered a guarantee of potential capability. Again, a conventional approach may be misleading. It is usually based upon the expectation that the aide will be competent to make written reports in line with professional practice, and that the ability to write will guarantee accuracy and completeness of observation.

The usual educational requirements made by agencies using such personnel (eighth or tenth grade) does not always guarantee effective literacy and does not always produce semi-professional written reports (even high school graduation does not guarantee this). It frequently creates expectations that are misleading. Such requirements will, of course, depend upon the types of assignments to be given the employee. Those programs which have not developed firm educational requirements have frequently noted that the ability to read simple instructions is adequate. Verbal reporting based upon direct observation by homemaker/aides who use their own words rather than conventional phrases learned by rote produces information which is far more honest, vivid, and informative than written stereotypes which tend to obscure the real situation.

Thus, it is possible that the requirement that the applicant be able to take down a name, address, and telephone number; follow instructions accurately; fill in a time sheet; and learn to call upon

appropriate resources in emergencies, will tap a large group of potential employees capable of good performance. Simple requirements such as these will, of course, mean that methods of training and supervision must be adapted to them. It is essential that those who do the training and provide the supervision guard against considering educational limitations a reflection upon the intellectual and emotional capacities of the employee. Only an inability to do the job based on the test of the work itself should be considered a valid estimate of the individual.

Work Experience

This very reliable factor in other fields of employment is unreliable here. Many of those applying will report that they have done "day work," and may present a fragmented and sporadic work history which cannot be checked. This should not create bias in the interviewer, who, if she is knowledgeable, will understand that the frequent change of household help is so common that it is not surprising that last year's employer does not remember the full name of last year's "cleaning woman" (if indeed she ever knew it). There will be occasional instances where applicants who have "taken care of sick people" will present a sheaf of enthusiastic letters of recommendation. These are routinely written by the families of chronically ill patients who change help frequently and necessarily, and who write mechanically without any real reference to or even understanding of what went on between patient and employee.

There are also occasional applicants who have had full-time employment of an institutional or semi-institutional nature. Such references are often poor, and there may be a good deal of resentment expressed on both sides. Frequently there may be an apparently suspicious vagueness about the whole area of work history. This may have arisen from areas of sensitivity about particular jobs which have nothing to do with capability (accusations of having "taken things"; of having not "done anything"; "wasted time"; of "disturbing other workers with job dissatisfaction"; of "rudeness"; or of "carelessness").

It should be borne in mind by the interviewer that such employment is usually undertaken in situations in which stress, pressures of overwork, and despair about illness and incapacity have resulted in the projection of unhappiness and dissatisfactions upon the employee, who was only minimally able to do anything about them. This also may leave the applicant with a sense of frustration and personal guilt which result in a decision to avoid the memory and present a blank page rather than what might be a productive and informative work history.

There is another common bias with respect to the absence of a work history that must be understood. This relates to the assumption that those who have never worked will be lacking in good "work habits"; that such desirable attributes as punctuality and reliability have not been established and therefore cannot be; and that those who are not accustomed to routine employment are apt to have a high absentee rate and are indifferent to the loss of employment. There has been considerable evidence in existing programs to contradict these assumptions. Good training and supervision directed at the purpose of the work will produce employees with the same attitudes as those in any other employment. If the program contemplates the employment of certain types of personnel because of special community needs—that is, women with families of small children or older workers who are less capable physically—there may be some increase in valid absenteeism because of the personal circumstances which prevail. However, applicants who have previously been considered expendable cheap labor, usually respond to the realization that they are depended upon, and that they are essential to an individual, an agency, or a community. They will give ample return when they realize that there will be consideration of their own unavoidable needs.

Occasionally there will be a good work history with good and verifiable references. These are in the minority, however, and the absence of such a history should not be prejudicial.

Health

In the course of the interview it is essential that the health status of the applicant be discussed. This is best done by inquiries as to whether there is regular contact with medical supervision (and this is not usually the case); the date of the last visit to a physician and the reason for the visit; and some discussion of the general health status. All programs require a health examination so that, unless there are obvious reasons which are apparent during the interview, a general impression of good health and vitality should be the basis upon which the interviewer makes her first judgment. Requests for employment that is "sheltered" or "light" should be carefully examined, and employment deferred until the physical basis for them is explored.

If employment will not endanger the applicant's health, and if there are indications that such an applicant's personality will be an asset, it is sometimes possible to make special assignments to such workers, where the program is large enough. In smaller programs, inevitably the pressures of heavy work tend to make it difficult to use such employees constructively.

Appearance

One of the most commonly accepted standards of appraising unskilled workers in a conventional screening process relates to appearance. It is generally assumed that those who seek employment will, if they are really interested, put their best foot forward with respect to the way they look when they are to be interviewed. It should be pleasing for the elderly infirm patient, or the family in distress, to see the person who comes to give help as someone who appears friendly, is neat and clean, and appears capable. The applicant who comes to the appointment appropriately dressed and who gives the general impression of personal cleanliness has already taken the first and important step in the recognition of an essential ingredient for employment. The fact that this step has not yet been taken, however, should not necessarily be an obstacle to a fair appraisal since, of all the elements in training which are the most immediately teachable, good grooming is probably at the top of the list.

Good homemaker/aides have developed from applicants who appeared for an initial interview overdressed, shabbily dressed, and without too much attention having been paid to the details of hair, fingernails and spotless clothing. Often this lack of attention to appearance is related either to an attitude of hopelessness about the possibilities of employment, inadequate access to resources which will produce a neat appearance, or an unawareness of how the circumstances will be affected by inattention to appearance. Day workers customarily wear the clothing which is at the point of discard to work, and do not consider their ability to perform the physical labor required to be in any way hampered by their own appearance.

There is, however, a type of dishevelment and inattention to appearance which may be an indication of illness, or lack of self-esteem so deeply rooted as to make the individual ill-suited to the work of helping others. This is a distinction which will come out in the interview. If, during the interview, there is a smile of responsiveness to the content of the work as described and an eagerness to try, if there is evidence of humor, sympathy, or comprehension, the fact that nail polish may be chipped, nails broken and unclean, hair not neatly worn or stockings torn, should be set aside long enough for the interviewer to visualize this same smiling, responsive person in a neat uniform, having been taught that the purpose of her appearance will be to give pleasure to those who need it.

As with unusual dishevelment, the tense, compulsively neat applicant, who appears to be lacking in humor, who demonstrates more interest in self than in others, and invests in appearance to

the exclusion of comfortable acceptance of self, may, in the end, provide less in service. It should be remembered that cleanliness can be taught more readily than sympathy.

Attitude

Attitude, of course, has the highest priority in the selection of trainees. What is sought here is not necessarily a verbalized attitude, nor necessarily a realized choice on the part of the applicant, but rather a potential which can be developed in the training process. It has no particular correlation with education, culture, age, sex, or previous work experience. It is not necessarily an expressed desire to "do good" or to "be useful." As a matter of fact, some of these expressions of interest should be examined with great care. An eagerness to be allied with medical or nursing services may be an asset; but it may also be an expression of a desire to control and manipulate others. The expressed desire to "help the sick or the poor," or to "work with people" may be valid interest; it may also be the expression of a desire for increased status of a variety that is least helpful to the sick, the infirm and the poor.

The presence of a *self-respecting* desire to earn a fair day's pay under circumstances which enhance that self-respect and consequently respect for others is probably as good a basis as any for making a selection. The artificial reasons just described may be advanced because the applicant is eager for work and believes that this is what the interviewer wishes to hear. A comfortable relaxed atmosphere, in which both the interviewer and applicant have an opportunity to discuss the work and what is essential to it, should as a rule go beyond these superficial expressions to real interests and capacities.

The interviewer must, as far as possible, bring out indications of bias which may not be modifiable and which will become an obstacle to good performance. For example, the applicant who expresses an interest in food may eventually be willing to discuss strong beliefs concerning the "impurities" in everything we eat or drink. Other examples are the applicant who, being herself religious, has strong convictions that the imposition of religious principles upon those she is helping will cure them of their ills; the applicant who has strong biases or dislikes for certain cultural groups, certain age groups; the applicant who may express in the course of discussion, unusual intolerance for working with women or unusual intolerance for working with men, as a result of past experiences or immaturity; or the applicant who wishes to "take care of the patient" and be relieved of all responsibility for household work, and who considers physical work demeaning.

Where unusual interest and sympathy are expressed for the sick, the infirm or disabled, over-involvement in the lives of others may become a danger. On the other hand, an appearance of efficiency, with strong tendencies to conform to all instructions, may be a handicap when independent judgment and intuitiveness are necessary.

Although these observations appear to narrow the field, they are made in order to clear away misconceptions which relate to a minority of the applicants usually interviewed in order to come to a common sense appraisal. In general, we have noted that the best applicant is one who is seriously seeking employment, and who in all probability would be interested in any other employment as well as this, provided it paid decent wages, had some prospect of continuity, and offered minimally acceptable working conditions. This is the usual reason for seeking employment, and in the long run it is the healthiest.

It should not be initially expected that a great enthusiasm for program purposes will be honestly expressed. In general, the applicant who comes with the attitude "I need a job," "I would like a good job," "I think I could do this one and I would like to try," will make a very good trainee. The temperamental aspects so essential to the work will not be ordinarily understood by the applicant, and they will not be voluntarily exhibited as evidence of fitness. Such evidence must be brought out if it is there by the skill and understanding of the interviewer. A desire to earn a decent living, a capacity for tolerance and understanding of the common needs of others, humor, interest in learning new skills and acquiring new relationships in the process of earning a living, and finally an indefinable quality—"warmth"—work best in these programs.

The word "warmth" may mean different things to different people, and for this reason the practice of having more than one interviewer see the same applicant may be helpful initially. Ultimately those who work with homemaker/aides do seem to develop a sensitivity to and appreciation of the many aspects in different individuals which combine to give the impression that the smile is a natural one; the interest in the job based on dignity and self-respect; and the humor a subtle consciousness of the common aspects of human need. These may be obscured by timidity or nervousness in the initial interview, or by the extreme assertive eagerness to prove suitability, but as a rule at some point or other, if a natural atmosphere is established, this quality or combination of qualities will be observed, if only fleetingly.

Variation in Service Needs

The interviewer who is screening for a larger program will understand that there will be a wide variation in service needs. She will know that

the quiet worker will be welcomed in some places and unwelcome in others, as will the worker who tends to be chatty and outgoing;

a slightly more rigid housekeeper will follow orders rigidly and will meet some needs;

one who prefers the helping aspects, who feels closer to the patient may give warm personal care; and

the youthful worker with a mature approach may provide greater stimulation to an older, lonely patient, but that the older worker with the same mature approach may do equally well.

The larger the program, the more scope there is for imagination and variety. In small programs, however, the interviewer will do well to attempt, as far as possible, to recognize and select the generally adaptable or "all purpose" trainee.

CHAPTER 9

Training the Homemaker/Home Health Aide

The common sense aspects of the homemaker/home health aide's work and the labor reservoir of unskilled persons from which to select trainees are likely to be misleading when we consider the purpose of training. One often hears comments such as the following:

> "What is so special about taking care of a sick child? My mother raised six, and nobody trained *her*."
>
> "Why do we have to send people to school to learn how to bathe somebody's sick grandmother? Neighbors used to come in and do it all the time."
>
> "How can we allow just anybody to go into a home where there is illness and safely take any responsibility? Some of us have gone to school for years to learn these things."
>
> "People who have never worked are too unreliable to be alone in households where there are serious medical and social problems."
>
> "By the time you provide the necessary supervision—and that's almost 100 percent of the time—you might as well use a professional in the first place."
>
> "The indigenous non-professional is the only person who can really meet the needs in his own group."
>
> "There is no substitute for the skills and basic knowledge built up in the professions over the years."
>
> "Unless you have worked in a homemaker/aide program it is difficult to imagine the rich potential of this group of individuals for service."

There is a great deal of truth in all of these observations. With variations, most of them can be and are being made about the use of non-professional personnel drawn from the ranks of the unemployed or underemployed for services in the home. It is true that frequently these persons have not had a standard education; that they work with individuals or families in which illness, disability, social or emotional dislocation or crises demand sustaining physical assistance, with skill required to provide it; and that

they most often perform these duties in the home where professional supervision is not constant or continuously available.

Major Premises of Training

If, however, we consider some of the major premises upon which both training and subsequent services are based, neither immoderate enthusiasm nor undue apprehension is in order:

We do not contemplate training the unskilled to "take over" the functions of the professional worker. We train for those services that have never been appropriate to the professional worker, or those which can be provided as well or better by nonprofessional personnel. One of the purposes of the training process (and this includes selection of trainees) is to build in the safeguards necessary to limit the services provided by the aide to those which she can safely provide.

We train because haphazard reliance on the common sense aspects of the tasks has not produced quality services in the past. "Just anybody" cannot take care of a sick child; and many a grandmother has sustained a fractured hip at the hands of a well-meaning neighbor.

We train to provide services which have not been provided at all before, or which have previously been in short supply, or in order to provide such services to sections of the population in need which have not existed in such relatively large numbers previously.

We draw from an unskilled group for training because experience has demonstrated that it is a rich resource. They are available; and there is some truth in the statement that usually (though not invariably) this group is untainted by the attitude that physical services are "menial" and therefore demeaning. Experience, compassion, generosity and common sense are less encumbered by false status values. (This does not mean that selection of trainees from this group can be indiscriminate).

The purpose of training is to supplement these attributes: to add insight and self-control to generosity and compassion; knowledge to common sense and experience; and to develop skills and special capabilities adapted to the widest possible range of situations.

The training of aides is a continuous process. It begins at the point of selection, proceeds through orientation and—whether the "basic" training is provided on the job, in organized sessions within the agency, in classes or schools established outside the agency, or in combinations of these—it will not terminate there, but will continue as long as the aide is employed.

For this reason, most agencies have found that they must be involved in the policies and procedures of the training program at every step: in the screening and selection of trainees, in the establishment of the relative emphasis to be given to various areas of content, in participating in the sessions themselves, and in planning for continuity by relating practical experience on the job to training content. For the trainee, the more evident the connection between training and employment, the greater the commitment to training content will be. Therefore many service programs prefer to select trainees themselves even when training is not provided within the agency.

THE PLAN FOR TRAINING

Training homemaker/home health aides will be most effective if it proceeds in accordance with a plan, rather than as a sporadic process. A plan involves a coordinated course with specific content that is related to program needs; selection of a faculty familiar with the program and having considerable understanding of the characteristics of the trainees and the most effective method of achieving training goals; regular assessment of the effectiveness of training measured by the effectiveness of homemaker/home health aide performance in the program; and adaptation of training to changing program needs.

Importance of a Training Coordinator

In order to achieve the necessary integration of training and employment, it is important that the responsibility for coordinating and directing the program be assumed by a single individual. She may then draw upon others with special competence to participate in planning the program content, the relative emphasis to be placed upon different areas of content, the length of training, and the choice of faculty and method.

Whether the coordinator is attached to a service program or is responsible for a centralized training program which serves one or more agencies in the community, she must be thoroughly familiar with the objectives, scope and policies of the service programs, and with the needs of the population to be served. This will involve the closest possible communication with the service programs regarding the success or failure of various aspects of training as they are tested in the field; the strengths and weaknesses of various aides in the course of training; and a capacity for flexibility in adjusting the training program. She may recruit faculty from the community, faculty may be provided by the service programs,

or it may be available in the training center itself. In all cases, however, the coordinator of training will be responsible for the orientation of faculty to the special needs of the aides and to the purposes of the service programs.

Where training is to be provided within the service program, these same responsibilities are best assigned to a single individual. Here too, those who supervise aides on the job must have an open channel to the training program, outlining the special areas of emphasis, and the failures and successes on the job which can be related to training and working with the training coordinator to provide for the needs of individual aides.

The role of the coordinator is one that requires considerable skill. Like the service administrator, the coordinator of training carries the final responsibility for the effectiveness of the training program. It is less important that the coordinator is a nurse, a social worker, an educator or a member of any particular professional group than it is that the individual selected possesses comprehensive knowledge of the field, is capable of planning and implementing a program which is realistic for the needs of the service, is skillful in the orientation and involvement of the faculty, and is very knowledgeable about the needs and capacities of individual trainees and of group(s) of trainees as they proceed through the training experience. The question "How well does the training work in the field?" is one which must be examined repeatedly by the coordinator. Objectivity about results and responsibility for a training design which will provide homemaker/home health aides who work with skill in the field is the primary goal.

Faculty

Whether or not the agency intends to embark upon the full range of services in its program, training will be most profitable if the students have an opportunity to come into contact with the full range of professions which provide services in the community or the home. The essential elements in training will focus upon agency responsibility, personal care, household management, nutrition, inter-personal relationships, and an understanding of the needs of children and adults in situations where illness, crisis and their attendant problems create the primary need. The instructors will necessarily come from the fields of nursing, medicine, social work, nutrition, and home economics. Where this range of professional skills is not readily available, it may be necessary to combine certain of these in one or two professional people, but it is preferable to bring those with specialized professional skills to the program.

The medical content may be provided by a private physician in the community, preferably one who is familiar with the home care needs of the sick and who can limit and modify medical information so that it relates specifically to the work the aide is to do. The responsibility here will be in the realization that a little knowledge is not a dangerous thing if the dangers are understood by those who present it. Another resource for teaching medical content may may be the health officer, who may combine this with a presentation on the prevention and control of communicable disease. A nurse—preferably a public health nurse—might present both of these sections. It is desirable that in the course of the training program the aide have contact with *both* the private physician and the health officer; and that the particularities of interest, point of view and differential function begin to become a part of her knowledge. The relationship of teacher and student is a good beginning upon which to build.

Personal care and all of the elements involved in it which are related to the personal hygiene of the aide as well as to the care of patients (both adults and children) can best be taught by a nurse. She might be a member of the staff, of the Visiting Nurse Association or the Public Health Department; or she could be a nurse from the program staff, a nurse who is teaching home nursing (such as Red Cross), a hospital nurse who has had some educational responsibility, or a professional nurse who has the experience or necessary qualifications to provide instruction.

In many programs, a comment is frequently made to the effect that "We don't want to make junior nurses out of these people." Here again, the reference is to the dangers of a little knowledge: this has particular meaning in the teaching of personal care skills. The instructor must be thoroughly familiar with the ways in which knowledge is to be used, capable of developing in the aides the kind of response which comes from a comfortable and trusting relationship, and quick and careful to observe the varying aptitudes of those she will be teaching. She, too, will have the additional responsibility of informing the aides about the different kinds of nurses, nursing programs and nursing responsibilities in the community, so that they may become important carriers of this information to their own families and friends, and to the families they serve.

Nutrition may be taught by a nutritionist consultant to the state or local health department, a hospital dietitian, or a home economist who has had additional course work in nutrition and foods. She must be aware of the special educational needs of the group, and must be thoroughly familiar with the social and economic characteristics of the population which is to receive aide services.

Usually this same personnel can be drawn upon to teach home management, home safety, marketing, and food handling and storage. Work simplification may, generally, also be taught in this context, but more specialized methods related to patient care may be taught by the nurse or physical therapist attached to rehabilitation centers, hospitals or special programs.

Interpersonal relationships, personal growth and development, the family and the community, and the social and emotional effects of illness are best taught by the social worker. This may be the medical social worker attached to a hospital or clinic, a social work consultant to the health department, a member of the staff of the Public Welfare Department or of a private agency such as the Family Service Agency, a member of the staff of the service agency, or a member of the teaching staff of a school of social work. Again, the development of understanding of the social worker as a member of a helping profession knowledgeable about behavior and about the maximum use of community resources for the benefit of its citizens must be an important part of what is learned.

Setting

The choice of setting will of course vary according to what is available in the community. The essentials are a comfortable classroom or conference room, and the availability of space and equipment for demonstration and/or practice. The opportunity for practical application of what is learned is essential. Some programs have provided their own facilities, using an agency conference room for discussion, bringing in the necessary equipment for demonstration, and providing opportunities for practical application, first with practice by the students on each other and then with practice in the home under very close supervision.

An alternative is the development in the community of a central training classroom or school. These have been developed by university extension programs, adult education programs, vocational training schools, and by a combination of a group of agencies using a central setting and utilizing agency professional staff as faculty. Practical training in personal care has been arranged in chronic disease hospitals or similar institutions; where these arrangements have been impractical, skills have been developed with on-the-job training under close supervision.

Some programs employ workers and provide a brief, intensive period of orientation in agency group conferences followed by a simplified field work experience through carefully selected assignments. As the workers begin to achieve some understanding of the work, they are sent for more intensive training to a centrally

organized training program serving the community or a larger area. One successful centralized training school based upon this pattern is established in an institution which has available rehabilitation facilities, chronic disease wards, an area for the demonstration of meal planning, preparation and serving, home management, and work simplification, with a faculty provided by the Adult Education program of the community.

The advantages of the institutional setting are the availability of facilities and equipment and a "professional" environment which familiarizes trainees with the various disciplines and with the emphasis on precision and uniformity in care procedures. Some of the disadvantages are inherent in the institutional setting itself: it is unlike the homes in which the homemaker/home health aides will function, and its impersonality may inculcate undesirable attitudes. When such a setting is combined with service assignments in the home as a part of the training process, and when the depersonalization of institutional routines is pointed out, these disadvantages may be avoided.

Home care assignments for the trainee must be carefully planned so that they are prepared for with "rehearsals," are closely supervised, and are well within the capacity of the trainee at each stage of training.

Duration of Training

Although there is considerable variation in the length of the training courses provided by established programs, there is general acceptance that formal training alone—regardless of the length of the course—will not produce adequately trained homemaker/aides unless it is supported by continuing in-service education. Formal training programs range from 20 to 400 hours of training; and the method of providing the training varies from a single session each week to daily training over a period of more than eight weeks. The longer training programs, however, usually include orientation and a block of post-training "field" or practical experience under the instructor's supervision.

There seems to be agreement that where formal training is provided in blocks of time, they are most successful if they are not extended over the entire range of the material to be taught but are provided in sections alternating with practical experience. Where the service program intends to develop more complex personal care services, the careful supervision of these skills—either in the course of the training program or as a kind of post-training internship—will have relatively greater importance, and may lengthen the formal training period in order to insure safe practice. Perhaps the best method of arriving at a decision con-

cerning the length of the course will be to adopt the practice of having those professionals who will be responsible for performance on the job, those who are to be involved in the training program, and other representatives from the field of practice review together the course content, assign relative weight to the various areas of training with particular reference to the program or programs contemplated, and to assign estimated blocks of time to these areas. The decision may then be made as to which aspects of the training are to be carried on the job, and which assigned to the formal training program. A regular review or assessment of how much is being achieved by the adopted method may then be established and the course revised accordingly.

Sequence of Training

The normal course of the training process may be divided into a series of stages, each focusing around the same general areas of knowledge and skill, and progressively adding to the depth and range of competence. These may be roughly outlined as follows:

1 A period of orientation.
2 "Core" training—an intensive period directed at the establishment of essential knowledge common to all aspects of the work and the development of basic practical skills.
3 A period of intensive on-the-job practice under close supervision in order to establish the pattern of service.
4 Brief "refresher" sessions to reinforce or stress observed areas of weakness.
5 Supplementary training to establish specialized techniques, skills or knowledge—either around selected individual situations or with selected trainees—in order to fill present or projected program needs.

Essentials of the Training Plan

The success of the training program will depend upon:

1 The close relationship of what is taught to the program in which the aides will be employed and the services which they are to provide.
2 The coordination and continuity of training so that each section of content is related to every other.
3 The development of basic knowledge and skill upon which later training can be built, with the objective that the aides will be prepared to undertake assignments with continued growth in understanding and competence.
4 The presentation of training material by those who have an understanding of the realities of the employment situation, skill

in working with non-professionals, and sufficient competence in special fields so that material presented may be readily understood.

METHODS OF TRAINING

Perhaps the most important aspect in the training of the non-professional worker will be the realization that formal training methods will not be very productive. The disciplines and routines of the classroom situation in which knowledge is acquired and tested by the recipient's ability to return it in an organized fashion are only acquired with long practice. The formality of the classroom—with its enforced physical inactivity and the anticipation that what is acquired there must be returned in written form or in response to organized questioning—is frustrating and inhibiting to those unaccustomed to this method of learning.

Informal Sessions Preferable

For this reason the best method of delivering information will be one which is informal, which establishes an atmosphere in which the relationship to the instructor is friendly and easy, in which learning material is related to the personal experiences of the trainee, and in which the testing of knowledge is based upon the evidence which the trainee gives of her understanding during the course of discussion and practice. Every effort should be made to establish the understanding that all responses will be accepted, examined, and understood, and that those which are rejected are not a reflection on the intelligence or capacity of the trainee, but the result of a mutually agreed upon realization that they may not be appropriate in given situations.

Those classroom sessions which are essential will be most productive if they are limited in time. Usually after an hour, the attention of the group will tend to wander; where two-hour classroom sessions are planned, these should be broken either with brief recesses or by a shift to other methods. Teaching is best done with this group by shifting from discussion to the use of visual aids or role playing, and interspersed with opportunities to practice what has been learned.

Some programs have found a successful combination in the assignment of the trainee to the training program for one half day, with the other half utilized in work with selected families or patients where the assignment will be within the trainee's initial capabilities. Such programs employ the worker prior to training, and following brief orientation give her one or two simple

assignments to be carried out either in the morning or the afternoon, with the alternate half day occupied in the training program itself. This has the advantage of providing the stimulation of interest which actual employment brings and, additionally, gives the supervisor an opportunity to understand how the trainee relates to the family and/or patient, and how well she is able to understand assignments and directions.

Thus, as she moves along in her acquisition of knowledge and skills, the trainee will naturally apply these, and will bring to the training sessions a more realistic reaction to what is taught. During the training sessions themselves it is possible to arrange for practical application of what is taught, not only in role playing but in demonstrations by the students using their own group first in such activities as work simplification, table setting, meal preparation, transfer activities, bed making, and ultimately, if the setting permits, by working with families under supervision.

Where written materials are provided, they must be vivid, visual, and arranged in a format that can be readily understood. A densely printed syllabus presents an initial barrier to the trainee. Language should be simple, and it should not be assumed that what is taught will be acquired by the student unless it is reviewed in the classroom setting. All written materials will be most helpful if they are presented as a reminder or in support of what has been discussed rather than as an independent responsibility of the trainee.

Usually the best results will be obtained if the trainee maintains a continuing responsibility to a single individual during the course of her training. This may be her supervisor in the agency which has employed her, with whom she may discuss her interests, fears or reservations. In this case, the supervisor will become a channel to the classroom situation. She may be the individual who will coordinate the training program itself.

Use of Everyday Language

During the entire course of the training, all language is chosen from everyday usage, and technical terms avoided. Where they must be used, they will best be translated or paraphrased so that there can be no confusion about their meaning. It is a refreshing challenge to the instructor to find new meaning in old established concepts in the simple speech paraphrased by the workers which is an indication that they have really been understood and acquired. It should not be assumed, however, that information given in a single session, however successful, will remain a part of the trainee's knowledge for all time. Throughout the course of training, and indeed throughout the course of employment, it will be

necessary to repeat and constantly review the essentials of what has been taught. It should not be assumed from this that the training should proceed in an atmosphere which is patronizing, or that the simplification of language and concepts means talking down to the group. All participants in the training program will need constant reminders that plain speech is just that; often enough, where there is an assumption that language skills imply superior knowledge, the trainees themselves will express in surprising ways their realization that they are being underestimated.

In much of the discussion about the life situations they will encounter, they will frequently if simply express *their* superior knowledge based upon a real familiarity through personal experience with such situations. During the course of the training, the coordinator or the instructor who is responsible for the continuing organization of training may find it necessary to bring specialized information into a frame of reference which is comfortable for the trainee. Misunderstanding which may be the result of differences in language usage will be common, and will only be cleared up if an atmosphere of mutual respect exists so that the different meanings which words have can be comfortably explored and the appropriate meaning for purposes of this training be established.

One of the important functions of training which can be rewarding to the student and the instructor alike will be the developing of increased skill in the trainee's use of language. Here, the emphasis will not be upon a change in the value or quality of the trainee's own language, but rather a constant attempt to assist in the development of accurate descriptive language usage.

Testing Techniques

During the initial periods of training it will be wise to avoid all testing techniques, and to measure what has been learned in a casual and informal way. This may be done at the end of a unit of learning by asking members of the group each to contribute an important aspect of what has been discussed during the course of the session. It may be reinforced at the beginning of each new session by assisting the group to review the material from the session immediately preceding or one which has taken place several days previously. However, no indication of disappointment over forgotten material will be helpful. A simple review on the assumption that new learning is not readily acquired will make it easier to evoke responses at future times.

Although humor will be an important component in the training process, the greatest care should be taken that ridicule never enters into it. It is assumed, of course, that this will not come from the instructor, but the laughter of the group which is based en-

tirely on pride in learning can be destructive to an individual trainee and may bar future participation. It can be tactfully turned aside.

When practical skills are being taught, the instructor will do well to understand the combination of eagerness and apprehension which may make for initial clumsiness. Here, too, the avoidance of ridicule and the development of an attitude in the group which provides constant reassurance and support will do a great deal to eliminate a continuing fear of failure.

The training sessions should be planned so that the course content is broken into small units; no single session should cover more material than is well within the capabilities of the group at that point in training. The program may be so organized, however, that time is a limitation. Where this is the case, the essential elements to be learned should be taught intensively and repetitively. More general aspects of the material may be outlined, and these may later be reinforced in on-the-job training or covered more intensively in supplementary training sessions.

COORDINATING TRAINING AND PRACTICE

When training is provided in a facility which is separated from the agency in which training assignments are given, or when training staff within the agency does not carry direct supervisory responsibility for practice assignments, *planned* methods of coordination are essential. This may be achieved in a variety of ways: involvement of faculty in discussions of agency objectives, policy and the pattern of service as a major element in insuring that training is pertinent to the projected work experience; the establishment of close working relationships between the supervisor responsible for the homemaker/home health aides in practice assignments and the faculty; regular joint agency-faculty evaluation of individual homemaker/home health aides (occasionally these may be very revealing). Aides who may not appear to be successful in the classroom may demonstrate great skill in their work assignments, while successful students may occasionally seem less adequate when they work in the field.

Joint evaluation of the training program at regular intervals may also be revealing, and this is important for different groups of homemaker/home health aides. The results of such regular evaluation may be the elimination of some sections of the training program as not essential to practice, or simplification or acceleration of training; or practice may demonstrate that training content is not being absorbed and a change in method, setting or faculty may be indicated.

The establishment by the coordinator of a mutually trusting atmosphere with a continuous channel of communication between faculty and practice supervisors will be an invaluable contribution to the training process.

Field Observation

It may be a valuable experience for the aide as a part of her training to be assigned for a day or two in a nursery school, a center for retarded children, or to spend a few days on children's wards, adult wards, or rehabilitation centers in the community, assisting in simple ways in order to gain understanding of the ways in which service may be provided. Such experiences, of course, will be of value provided that all personnel connected with these services have some understanding of the purpose of the training, and relate what is observed to the activities which the aide herself will undertake. It will also offer the training staff an opportunity to observe the responses of the group to the material presented so that it may be amplified and reinforced as necessary in later sessions.

Perhaps the most important element in the atmosphere of the training of the group will be the firm establishment of the idea that the services for which the training is provided are greatly needed, and that in acquiring the essential skills the group may look forward to becoming a part of the employed section of the community in work which is constructive and usable in a variety of situations.

CHAPTER 10

The Training Program: Orientation

The period of orientation is intended to establish a basic understanding of the service program, its place in the community, its goals, and the responsibilities of the homemaker/home health aide in the program. An introduction to the basic approach in the home and emphasis on agency policy and its rationale with respect to the aide's performance are a part of orientation.

Orientation may be provided prior to practice experience, or concurrently with limited on-the-job experience. When orientation is provided prior to practice—which, in effect, becomes a series of lecture discussions—the material will best be presented in small units, in logical sequence, with a good deal of review and with every effort made to draw on the trainee's own experience to illustrate what it taught. (It is important to note that classroom learning for those not accustomed to it tends to remain a purely verbal experience and is only related to action and to real behavior with considerable effort).

In programs which combine orientation with employment, no personal care is involved during orientation. Agencies select assignments in which, because of convalescence or the need for a period of general maintenance, it will be possible to give the new trainee one or two simple experiences. It is an invaluable opportunity for the supervisor to begin to develop a relationship with the trainee and to prepare her for more formal training. Temperament, special aptitudes and certain weaknesses can thus be observed, and will be of assistance to the coordinator of instruction during the formal training period. Certain aspects of the training may be planned to strengthen areas of weakness in groups of trainees. A baseline is established during the course of training, employment and later assignments from which either to evaluate growth or to make use of temperamental strengths and capabilities which may be useful in specialized assignments.

Certain of the trainees, for example, turn out to be imaginative cooks, and are particularly helpful where diet is a problem; others will exhibit a quality of tenderness which is most helpful with very disturbed children or adults and with individuals who

have had recent serious illness. Similarly, certain trainees show very early a natural feeling for household management and household organization which adapts well to family assignments or those in which elderly individuals have maintained a rather compulsive setting and are disturbed by disorganization.

Such aptitudes may be combined with weaknesses: the good cook may not be a good observer; the gentle helper may adapt wonderfully to the physical care of patients but ignore sanitary precautions; and the fine housekeeper may tend to impose her opinions upon others. These characteristics observed during the orientation period may be carefully discussed with the coordinator of the basic training program. Training can thus carry the necessary emphasis.

The orientation period is perhaps the only one in which at least a part of the material will be presented somewhat arbitrarily. If the trainee is to begin to provide service, those aspects of policy which will provide protection for her and those she serves must be firmly established, and certain rules and regulations must be accepted on faith, although in every case a simple supporting explanation should be given and an effort made to achieve an understanding that all rules have a constructive purpose.

EXPLAINING THE AGENCY

As a starting point, orientation explores the trainee's own understanding of the employing agency, its relationship to the community, and her place in the program. The purpose of community organizations which provide service may be briefly described, but the major emphasis will be on the employing agency itself: how it was established and by whom; its source of funds; its primary goals and objectives; the specific services it provides; who the recipients of service will be; and, briefly, what the general policies are concerning eligibility and the limits of service. Here there will be questioning as to eligibility, particularly with respect to payment for service. When, invariably, the question is asked whether those who receive service are required to pay, one of the first arbitrary requirements will be emphasized. Regardless of whether or not the agency has a range of payment plans, the trainee must clearly understand that the family's right to privacy with respect to all aspects of its relationships to the agency must be respected. It is usually a policy that trainees are not given information concerning the payment plan, and that no discussion of the family's financial situation will be initiated by the trainee. She will be asked to refer all questions of this kind to her supervisor, but she will also be asked to observe those situations in

which family resources appear limited so that she may be particularly careful in handling shopping, suggesting expenditures for equipment or supplies, and, where financial emergencies arise, to refer them to the supervisor.

The kinds of professional personnel employed in the agency and their functions will be described, with particular reference to their relationship to the trainee and her activities. The relationship of the trainee to the supervisor must be established at this time, and a good deal of emphasis placed upon her freedom to turn to the supervisor at all times. The refrain: "if you are not sure, ask your supervisor" is a constant one throughout orientation.

Specific Duties of Aides Outlined

Although a *general* description of the agency's services may be provided, the *specific* duties which the trainee is to perform at this time must be carefully outlined, and limits sharply defined. In general, the trainees will be eager to move into personal care activities as early as possible. This, when it is recognized, will provide an opportunity for discussion of adherence to a *specified plan of work*. The prospect that further training will be provided in personal care when the orientation program has been thoroughly absorbed (and this varies with individual trainees) becomes an incentive.

In connection with these first assignments, possible anticipated emergencies will be described: the trainee is given specific directions as to which personnel will be responsible, how to obtain assistance, and what her behavior must be. The importance of a calm, reassuring attitude is stressed. It is important that a distinction be made between remaining calm and self-assured in an emergency and an unwise assumption of responsibility for service or activity which is not within her capacity. Her first assignment will be given to her with careful attention to detail and ample opportunity for questions. She will be prepared for what she will find when she makes her first visit, and her services will be limited to those which she can comfortably perform.

This will be the beginning of the development of an understanding of the agency, its service program as a part of the community, and the relationship of the trainee to the program.

It is not difficult to establish in such a group the idea that individual, cultural and economic differences must be respected. Where difficulties do arise, they come about because of the trainee's eagerness to be of help, and frequently because her understanding of what may be needed has not yet developed sufficiently so that she can see need as something separate from what she herself might require in the same situation. This material will best be

presented by specific and vivid examples of differences in personality, culture, and life situations which may initially seem strange; the best emphasis will be on the very accessible recognition that individuals have rights which must be respected.

Case examples, situations drawn from the trainee's own experience, and "what would you do if someone said this to you. . .?" as a focus for discussion will begin to develop the perception that the aide, in performing as a helping individual, has *a different kind of responsibility* than she might have as a friend, neighbor or family member, and that her responses must be based upon a different kind of consideration.

UNDERSTANDING AGENCY POLICY

In this section, the rules and regulations of the agency are established and explained:

Confidentiality

Emphasis upon the individual's right to privacy will lead naturally to an understanding that however minor and unimportant information gained in the home may seem, this is personal to the family and may not be shared with anyone except the supervisor. Many agencies establish a practice of training aides not to use family names even in group discussions with one another; and where assignments are given on the telephone, the aide is asked not to repeat the name even at that time but simply to ask that it be repeated or spelled. This minute attention to the preservation of confidentiality establishes a firm pattern which will endure if it is constantly reinforced.

The interest and excitement the trainees do feel at participating in the lives of others is a very tempting subject for conversation and discussion; thus, illustrations from real situations which stress the importance of confidentiality will be the most convincing. In one admittedly unusual example, a supervisor was able to relate to the group a verbatim account between two aides in which they described in great detail the idiosyncrasies of two of their clients. The supervisor—unseen and not deliberately eavesdropping until she heard the familiar family names—was sitting behind them on a bus. The group reacted with laughter and confusion, but there was agreement that none of them would have enjoyed being publicly discussed in this fashion.

The trainee is also asked not to discuss one family with another, although it is always pointed out that harmless gossip related to subjects not personal either to the trainee or the family is often welcome to those whose contacts are limited.

Personal Discussion

Another requirement is that the aide may not discuss *her own* personal affairs with the families she serves. This, too, is often a great temptation, since the contact is an intimate and continuing one; and curiosity may be great on one side and the temptation to share and confide equally great on the other. As this may be a particularly difficult rule to observe in periods of stress for the aide, it must be carefully discussed during the period of orientation; and the trainee must be assured that where personal stress or fatigue become problems for her she may, at any time, share this with her supervisor and receive help and support. She is asked to see herself in a position of providing assurance and strength when she comes into the home to help, and as a person capable of putting aside personal unhappiness or worry during the period that she is there.

When problems which are either personal or related to illness are brought up by the family, the aide is asked to be a willing listener, to observe and report changes or difficulties, but to refrain from giving advice. This will be particularly true where the treatment program is discussed. Here, again, there is a great temptation to compare symptoms and to suggest medication which has seemingly been effective in another situation known either to the aide or to her friends. Problems involving marital difficulties, the behavior of children, or decisions about placement of children or adults will inevitably be brought to the attention of the aide because of her intimate contact with the family. It should be stressed that these require the skills of the professional staff and that advice, however well intentioned, should not be given by the aide.

Again, illustrative examples can be presented, but care should be taken to avoid the implication that dire consequences will ensue. A threatening approach which implies that some minor infraction will bring about the loss of employment is defeating. The trainee must be encouraged to report easily to her supervisor any inadvertent infringement of the rules which may have occurred. Such a confident exchange will lay the foundation for the establishment of this same principle at a later time when personal care is being taught, and when it is of the greatest importance that the trainee feel free to turn to her supervisor without fear of jeopardizing her employment.

Gifts and Punctuality

When the trainee is told that she may neither give nor exchange gifts, even small ones, there will usually be expressions of surprise. It will be difficult initially to establish the fact that the gift giving, gift receiving relationship establishes mutual obligations

which are not appropriate to the service. Similarly, a conscientious approach to punctuality must be stressed. Difficulties in the family are described. The vivid example of a lonely old lady, who wept bitterly each time the aide appeared five minutes late because she assumed the service had been taken away from her, will usually give meaning to the need for arriving as scheduled.

This will be strengthened by a somewhat permissive attitude initially concerning unavoidable delays. The trainee may be informed that if delays occur, she need only telephone to say that she has been delayed so that the family may be notified. It is interesting that after a time or two, the extra effort that the professional staff is willing to assume in these circumstances tends to reduce tardiness except in truly unavoidable situations.

A more difficult problem is the establishment of adherence to schedule. Quite often, without agency knowledge, either the family or the aide, or both, will agree that a 2:00 o'clock to 4:00 o'clock schedule is less convenient than a 10:00 to 12:00 o'clock schedule, and will make an independent shift. The situation is best described during the orientation period with discussions about what might possibly happen as a result: namely that efforts to reach the aide in an emergency or for essential assignments elsewhere will fail, and that another family needing service may be forced to do without.

Here, again, the best appeal will be to the aide's concern for individual urgent need. Being a good employee may be for her like being a good pupil in school, being a good child at home, or being a member of a conventional establishment in society, against all of which she may have had rebellious feelings—and such values may have been habitually disregarded. An injury to others in need, however, will be less easily disregarded; and her role as a steady, helping person who adds security and stability to a situation which may be shaky and chaotic will be one which she can most readily understand and accept.

Interpersonal Difficulties

Injustice and verbal mistreatment normally stimulate an aggressive and self-protective response; and this is particularly true in a group to which life has taught hard lessons in self-protection. It is therefore particularly difficult initially to insist that, *no matter what the provocation* may be in the home, the aide must preserve a calm demeanor. She should be prepared for the fact that expressions of dissatisfaction may be the prevailing mood in the household. She should be assured that her supervisor will give her help in dealing with this, but that she must not be provoked under any circumstances into argument or retaliation.

This is often difficult to accept, particularly when her initial experience will be one in which she is eager to please. It should be stressed that such expressions will more frequently be related to personal discomfort and unhappiness in the household than to her personality or activities. As a helping person, she will be expected to remain calm and cheerful and to turn to her supervisor for help rather than to attempt to deal with these situations alone. In this respect, there must be acceptance of the fact that she may not feel positively about everyone she meets; there may be some personality traits in adults or children which she dislikes, and to which she finds herself reacting with irritation. In such situations she must understand that she may freely discuss her reactions with her supervisor, and if no reasonable solution can be found, a shift in assignment will be made.

While this may seem to be an unusually flexible approach, it is one of the best methods for insuring stability and continuity of service. The aide who finds in her employer a realization that some situations are intolerable for her and does not find this a reflection on her capabilities will more quickly come to understand the same dislike in others and will develop considerable ability to tolerate it.

Relationship with the Family

In the beginning, trainees will need help in establishing the pattern of relationship with each family. It is often helpful to discuss with the group the ways in which the initial entry into the home may be made and the manner in which routines which fit into the normal pattern of living may be established. Difficulties may arise because the professional staff has scheduled time which is not convenient for the family; and it is important that the aide not be caught between the agency and family. She should fell free to discuss with her supervisor the dissatisfactions which are expressed. It may not be normal for the recipient to bathe, or have a main meal, or be taken out at the time which is convenient in the schedule. The responsibility for resolving these difficulties should not be placed upon the aide. When the decision has been made, however, she can be helped to sustain it; but she must never be forced to impose it arbitrarily, nor be allowed to do so.

This will be equally true in the case of therapeutic routines which are resisted or avoided. The voice of authority is not appropriate for the aide. It will make a sustained relationship impossible; and it imposes unusual responsibility on a nonprofessional worker. From the beginning of orientation, the trainee must understand that these situations will be the supervisor's

responsibility. In this respect, most agencies have found that certain policies protect the aide in her relationships with the families and individuals she serves:

Neither the aide nor the family is on a first-name basis. Many trainees will have come from "day work" where they were known only by their first names. They must be taught to introduce themselves as "Miss" or "Mrs." Similarly, the aide will not refer to older persons either by the first name; or—adopting a rapidly disappearing professional practice—address people as "grandad" or "mother." Unless everyone in the agency is on a first-name basis, the same practice should prevail between supervisor or instructor and aide. (There will be instances when real friendship develops between aide and recipient. They may then call each other by the names comfortable for them; this, however, will be by mutual agreement.)

The aide does not give her telephone number or address to the individual or family unless this has been previously planned by the supervisor. She may be reached only through the agency. This will eliminate the possibility of independent arrangements or requests.

The aide is instructed not to use the household telephone for her personal calls. Where calls to the agency are necessary because of an emergency, an exception is made. All other calls to the agency are made between assignments.

Unless previously planned with the supervisor, the aide does not have her meals with the family. Usually time is allowed for an early lunch or a late one, if the assignment includes meal preparation. If this is not possible, the aide will bring her own lunch. Occasionally, particularly where there are children or lone individuals, it may be desirable to plan that the aide have tea or coffee with the individual. This is often welcomed, but these arrangements sometimes develop awkwardly and should be the exception.

If the aide is to shop, pay bills or handle family money, specific arrangements will be made as to how this is to be done. Some agencies provide for written receipts; others require that a separate coin purse be carried by the aide in which "family" money is kept, and shop tags and change are returned.

The aide will not be asked to inform the individual or family of changes in schedule, reductions in time allotted, or the fact that service is to be discontinued. She will usually be informed that such changes are imminent, but should be instructed carefully that this information will be given to the family by her supervisor.

Shifts in assignment are often difficult for the aide. She will

have become attached to her family, comfortable in the routines that she knows, and happy in the knowledge that she is welcome. She will be reluctant to give this up for an unknown situation and the sad remark, "I am not coming to you any more," is made with genuine regret and the understandable hope that if the individual "gets upset" or "doesn't want to give her up," she may be permitted to remain. In time she will come to understand her role more clearly, and to make such changes cheerfully; she should not, however, be asked to deal with explanations about changes in plan although she may be assisted in helping to bring about the necessary adjustment once it is made.

PRACTICAL KNOWLEDGE AND SKILLS

Since, during the orientation period, no personal care services will be involved, training centers around the basic elements of sanitation, personal grooming, food preparation and household maintenance.

Personal Grooming

This material will be most acceptable if it is presented in an objective and matter-of-fact way. There should be no implication that it is a reflection on personal habits of dress or cleanliness. The idea that a uniform and certain consistency in appearance are important to the agency's program is a sound basis upon which to begin to establish ideas of grooming. Then the requirements may be enumerated, and trainees asked to avoid, for the purposes of employment only, those elements in grooming which make for an extreme or exaggerated impression.

The instructor will point out that if the aide is to teach by example she, herself, must appear with her hair shampooed and neatly combed and her skin clean. During demonstrations of hand-washing techniques, which are a part of the orientation, the care of hands and nails can be emphasized. The fact that those who are ill are frequently sensitive to odors may be the basis for discussing the elimination of heavily-scented makeup, and explaining the use of deodorants.

The provision of uniforms, of course, will tend to develop a sense of pride and responsibility with respect to grooming. The choice of uniform should include some attention to ease in laundering, durability, and a sufficient supply so that the aide is not forced to launder and wear the same uniform over and over again.

Household Maintenance

Programs differ as to the kind and amount of household maintenance provided by aides. Where services are to be given to an older population, the predominance of individuals living alone or in two family units housed in single rooms or small apartments make it difficult to maintain a policy that only very limited housework will be done. On the other hand, the relationship of aide assignments to situations in which there is illness may preclude extensive housework.

During the period of orientation, it should be stressed that only those tasks which have been specifically included in the assignment should be undertaken, and that requests for additional services be referred to the supervisor. Usually assigned tasks include changing of bed linen, care of the bathroom, simple housework which will maintain a clean environment (i.e., dusting, sweeping, mopping, dishwashing, and disposal of garbage). The aide is not usually assigned a heavy household laundry, although she may prepare laundry to be taken out, or herself take it to a laundromat if one is available nearby. She will usually do personal laundry in the home.

The demonstration of hand-washing is accompanied by particular emphasis upon food handling, with instruction concerning general household sanitation. This will also include the handling of soiled linen, care of dishes and utensils used by those who are ill, and care of the bathroom. Some programs also include at this time beginning instruction in work simplification. During her first assignment, the trainee should be asked to report if the work in the household is unusually heavy, if the time allotted appears to be too brief for the work to be done, and if adequate equipment is not available. She should be instructed to report this to her supervisor before asking the family to make major purchases

Food

The simple elements of an adequate diet are outlined. Unless there are specific instructions around a particular family situation, the trainee is instructed initially to observe the family pattern and attempt, wherever possible, to suggest foods that make for a well-balanced diet. This may include some discussion of special needs: the limitations which dentures may impose; emphasis on soft or smooth foods; special needs of children, and acceptable—if bizarre—food habits. This information should be presented in concrete rather than theoretical terms. The trainee should be instructed to shop as carefully as possible and to allow the family to indicate preferences in meal planning and the preparation of food.

Home Safety

During the orientation period a brief discussion of the major hazards should be briefly outlined. These will include: proper handling of electrical equipment and changing light bulbs; climbing on rickety chairs to reach high shelves; protecting those who are ill and unsteady on their feet from scatter rugs which may slip; avoiding the use of household sprays and disinfectants without proper regard for instructions; storing medications, cleaning supplies, knives, scissors, and sharp instruments away from children; and similar simple rules for the prevention of accidents in the home.

General instructions at this time should be given in a fairly routine manner. The trainee should be instructed specifically about emergencies which may be expected to arise, what action is to be taken. In addition to an open channel to the supervisor, she should understand how to call the fire department, the police department, and the family's physician. She should be told what to do in case of an accident to herself on the job. And she should be instructed that she is not to report to the home if she is not feeling well, but rather to report to the agency so that a substitution can be made. In this regard, it should be made very clear that it is not only her health which is important, but that what is a slight cold or headache for her may turn into something more serious if it is communicated in a family where there is already illness or disability. She should, therefore, be encouraged to use her sick leave whenever this seems indicated.

Paper Work

As previously indicated, paper work should be kept to a minimum. Whatever is required, however, should be carefully explained. If a time sheet is kept, the method used should be demonstrated and the same freedom to question allowed as in any other part of the instruction. Precise information should also be provided concerning sick leave, vacation, payment for overtime, the maintenance of "expense" vouchers for carfare and similar records.

If extensive recording concerning the patient's status will be required by the agency, this will best be postponed to the period of "core" training. Recording is intimidating to most people; the trainee will be using most of her energy during the orientation period in learning to be comfortable in her new role.

SUMMARY

In summary, orientation occurs prior to the "core" training period. It may be provided in the agency by agency staff—with

supplementation from outside the agency if necessary. It is intended to familiarize the trainee with work in an organized program, and with established policies through structured channels of supervision. If practical experience is provided concurrently, the orientation provides the essential information which safeguards the initial experience and gives the agency an opportunity to evaluate the capabilities of the trainee before investing in extensive training. If orientation is not to be provided by the agency with concurrent work experience, it may be included in the "core" training program as a preliminary to practical application and more intensive training. If concurrent work experience is eliminated entirely, those aspects of the orientation program which relate to the policies and procedures of the agency will still best be provided *prior* to work assignments. The approximate time suggested for orientation is about 10 percent of the total training time.

CHAPTER 11

The Core Training Program

Progression of the trainee through a planned sequence—orientation, training in basic knowledge and practical skills, actual practice under intensive supervision, constant reinforcement or "refresher" sessions, and instruction in specialized techniques—can be natural and logical. Application of arbitrary time limits for perfect achievement in each step for the individual trainee is not. Not all trainees will acquire the essential content at every level at the same rate. The training program itself will be an important tool in evaluating the capabilities of individual trainees in specific aspects of their work; those who cannot achieve well in one sequence may do exceptionally well in others. Special arrangements may be necessary—either through selection of small groups for reinforcement of content, postponement of practice assignments in the home, or individual conferences with supervisors or faculty. Trainees who, after a substantial period of trial, are unable to acquire the essential attitudes and skills may not be suited to work in the field.

It is important to consider that timidity, unfamiliarity with all training procedures, and the fact that not all trainees will perform equally well in every phase of the training, all play a part in performance during training. When every trainee is given a fair opportunity to adjust to training and to learn what must be learned, those who are not able to perform successfully will usually realize that they are not comfortable in the work. However, with careful selection of trainees, this should not be a common occurrence.

The core training program is intended to provide basic information and skills which will prepare the aide so that full utilization of her services will be possible in all but specialized situations. It should establish her understanding of her role; of the functions of the various professional personnel with whom she may work, their special skills, and the nature of her relationship to them. It should establish her own skills in practical and personal services. It should begin to establish the knowledge of what is available in the community. It should impart understanding of the responsibilities of the various community agencies and their

essential functions. Thus, the aide who, of all the staff, will come into the most durable relationship with the families in need may become an important carrier of information.

For the family which mistrusts community agencies, the aide who is most continuously in the home may be the best person to explain in her own way the importance of regular attendance at a well-baby clinic, the purpose of immunization, and the guarantee which pre-natal care provides. For the elderly, chronically ill, apprehensive patient—fearful about troubling her doctor—the aide may be the best person to encourage regular health care and may be of real support in helping to bring this about. For the disabled or troubled adolescent, who may find it impossible to accept limitations and to redirect energy, the aide may be the least threatening and the most quietly encouraging and helpful member of the therapeutic team. The unobtrusive re-establishment of good food habits for the convalescent, and the adaptation of good nutrition by the deprived family may be more readily accomplished by the aide than by innumerable sets of professional instruction, even when they are accompanied by attractive illustrated pamphlets.

In the final analysis, the slow building of habits of feeling, thought, behavior, and ways of life are best done on a minute-to-minute, hour-to-hour basis. This will be well within the aide's area of activity provided she, herself, has a fairly thorough understanding of what is essential.

This, however, does not imply that the core training program should shift the attitudes of the trainee so that the very values which she possesses are distorted with too little technical knowledge about the wrong things. It is not necessary to supply the trainee with confusing diagnostic information which may be distorted, misunderstood and misinterpreted, in order to teach her how to help a patient move from bed to chair, how to attach or remove a child's braces, how to help an overwrought mother when family pressures become acute, or even how to observe physical changes and report them. She will not require complicated technical information regarding nutrition in order to learn and perhaps to teach what an infant, a growing child, or a fragile, elderly cardiac patient needs in the way of daily food.

The aim of core training will be to provide her with practical information, to deepen her understanding of herself, of others, and of the immediate and community environment, and to develop simple skills so that she may become an important element in the comprehensive range of services necessary in the community. Both in the training of the aide and in her work with families, the clear objective will be to support values, whether they are indi-

vidual or cultural. The danger in training the non-professional and in reaching a broader group through the non-professional is in setting up, either specifically or by inference, values and objectives in a context which ignores or deplores regional, cultural, ethnic and individual difference. The value of the aide's contribution will lie in maintaining these, at the same time providing her with knowledge that she may be in the best position to transmit. If, inherent in the training, there is a prevalent attitude that the best preservation of an ethnic or cultural pattern of life is to reduce infant mortality, lengthen life and strengthen self-esteem, then the aide may be in a stronger position to assist the agency in its purpose when she has grasped these objectives.

Initiation of Core Training

The initiation of the core training program will be somewhat different from the period of orientation. The general program of training may be briefly outlined, and the method of training explained. Here, there must be a clear understanding on the part of the trainee as to whether she will be judged in those ways which she usually associates with school, or whether the training has been established in a different frame of reference. It should be stressed that any evaluation or testing that is done will be for the purpose of measuring *individual* growth, will be *non-competitive*, and will serve to assist the instructor as much as the students. From the beginning an atmosphere which allows for free questioning should be established.

Initially, and usually throughout the training program, there will be frequent questions—both direct and oblique—about the relationship of performance in the training programs to getting and keeping employment. *Before the trainees will be willing to share information, opinions, reactions, and confessions it will be necessary for them to understand clearly where the jeopardy lies with respect to the job.* If the supervisor and instructor are the same person, she herself must first be clear about this and must then honestly state her position with respect to the use that will be made of the material that comes out in the course of training. If the instructor is not attached to the agency or the employment situation, again there must be both clarity and honesty about the transmission or use of material obtained either through periodic evaluation or in the course of training.

In order to arrive at this clarity, it might be well to formulate those aspects of practice, temperament and capability which, if they appear, might be conclusive evidence that a given individual cannot learn to be a good aide. These should not be numerous—they might well include a total preoccupation with self which may be-

come a permanent barrier to the understanding of others; an apprehensiveness or physical clumsiness in the performance of tasks which cannot be eliminated by training and which will be a barrier to providing personal care; or a demonstrated inability over a period of time to acquire and retain essential information. It should be made clear, however, that there will be ample time for each trainee to acquire the necessary skills and understanding, and that arbitrary conclusions will not be made on the basis of an individual performance, *but only over a period of time.*

DEVELOPMENT OF MAJOR CONTENT AREAS

The Community and Its Responsibilities

First, the basic responsibilities of the community are more specifically described. This material will have more meaning if the trainees themselves are allowed to tell what they know about much that is taken for granted in daily life: clean water, pure food, the control of communicable disease, the prevention of illness, concern for family life, the promotion of economic security, what is meant by mental health, the treatment of mental illness, and the protection of individual rights.

From this discussion, more specific knowledge can be given about the agency (or agencies) through which these responsibilities are expressed in service. Here, the concept of the meaning of the word "agency" may be more clearly established. Beginning with the agency in which the trainee will be working, she should receive a thorough description of its purpose and function and its relationship to other agencies in the community. As the activities, functions and purposes of other agencies are brought into the training program, understanding will be most effectively developed if they are related to the function of the agency in which the trainee will work and with which she is perhaps already familiar. The personnel in her own agency may now be more clearly described, their activities understood in greater depth. As the trainee comes to understand that this agency, whether public or private, carries on certain activities, the related or similar activities of personnel in other community agencies may be discussed.

Such material is best presented if the discussion or didactic sessions are varied. This will be an opportunity to bring the trainee into contact with the actual work of other agencies or services in the community. Representatives from the professions, the Health Department, the Family Agency, or the Welfare Department may take over parts of these sessions, describing their agencies, their purpose, how they are financed, and how services are

obtained. The emphasis here will be upon providing the trainee with simple information concerning the resources which the community offers to families and individuals.

The instructor should bring out clearly those aspects of each program which may be useful to the aide in her work; this will involve complete honesty in the presentation. For example, a program which may seem generally useful, but which is limited because it does not provide services in volume, should be so presented; programs in which there have been difficulties in meeting eligibility requirements should be explained; and those which are readily available but generally poorly understood should be clearly described. The trainees should be encouraged to question freely; where needed services are lacking, this should be frankly acknowledged and the ways in which communities develop needed programs discussed.

If the discussion is free, the trainees will bring to it a good deal of personal experience, some of it unhappy, concerning efforts to get help, either for themselves or others. They will also bring a good deal of misinformation: "doctors practice on the poor people in clinics"; "the welfare can lose your job"; "the health people can report you to the school and they make it hard on your kids"; "if you don't do what they say you're in trouble"; or "they make you wait three months and by that time you don't need them any more."

The responses to some of these statements will come readily; some will be more difficult, depending, of course, on the community. In discussing the community and its services, the instructor should bear in mind *that what the aide really believes to be true will be carried with her into her work with families.*

Responsibilities of Service Personnel

Presentation of the work of the various professions and their responsibilities will be best presented if the field of knowledge, the method of practice, and the relationship of each to the others can be stressed. When the physician provides the trainees with the simple medical information necessary for their work, it will help if he also explains why, in each situation, he must be the person who is responsible for the treatment program, and the reason that changes in the program made independently of him may have serious consequences. The ways in which he uses nursing services and the nurse's responsibility to him will open the way for further development of the trainee's understanding of the underlying reasons for the chain of responsibility that must prevail.

The objective here is to eliminate through understanding the

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"we" and "they" attitude which may exist. If the doctor cannot do his job appropriately unless the nurse does hers, the trainee will begin to understand that she, too, has an appropriate responsibility. Presentation of the nurse's role must be made with even greater care, because in their work together the trainee will observe that she is, to a limited extent, participating in the physical care of the patient. It will be helpful if, along with her discussion of the ways in which the nurse carries out the treatment program, the emphasis is upon what the nurse will be teaching the trainee to do. Her role as teacher throughout the course of employment will develop in the trainee the realization that she will turn to the nurse to be helped to do what is appropriate

At the same time, however, it is important to stimulate in the trainee the ability to observe and report what she sees. Independence of observation is not what must be discouraged. It is independence of action, particularly in personal care, that must be discouraged so there is understanding that the safeguards which have been established have some real meaning.

The social worker, who may find that she is understood in the wrong context—i.e., as the eligibility barrier, the person who "checks up" the "relief worker"—will find herself viewed somewhat differently when, after dealing with these reactions, she can go on to the ways in which behavior affects the care plan; the effect of the social and economic environment upon human ability to handle or tolerate stress; and the use of professional understanding to enable maximum use of the services. She may then become the source of help to the trainee in her understanding of herself and become an important channel to the development of sound interpersonal relationships.

The extent to which other professional personnel are brought into the training program at this time (i.e., physical therapists, occupational therapists, nutritionists) will depend upon the time available and the extent to which they will be directly active in the service program. They will be involved in the teaching of practical skills; at that time, the relationship of what is taught to the plan of care and all those who are involved in it must be similarly stressed.

THE INDIVIDUAL AND THE FAMILY

One of the limitations of much of the material available for teaching and learning is its reliance upon an experience context that may be alien both to the trainee and to those needing her

services. This is not to say that the basic elements in what is known about emotional growth and development cannot be taught and fruitfully used. It does imply, however, that if self-knowledge and the knowledge of others are to be acquired in the course of training, it must be divested of conventionality and of reliance upon norms that are accepted only in a given culture or a given economic pattern of living. If we can only assume, for example, that the "normal" pattern of family life must be based, for the child, upon the existence of both parents in a stable relationship, we eliminate the whole range of experiences, adaptations, and adjustments through which children acquire security and experience for growth from sources other than this one; i.e., the transient father who may nevertheless supply what is needed; the older sibling who assumes parental responsibilities; or the interaction between members of a cultural or economic group which provide the essential elements of security.

These may not necessarily look like the pictures in the pamphlets of happy, secure children with nurturing parents in a clean environment; but they may, nevertheless, provide the emotional sustenance which makes for growth and health. Conventional teaching of the aides which relies entirely upon these may evoke considerable amusement. When assumptions are made about the capacities of children for independence, for example, information which is transmitted upon the basis of what is known about the "average" American family with its quota of 2.3 children, with both parents in the home, and with aspirations which appear irrelevant and unrealistic, will be set aside by the trainee who, from experience in large families, may understand the capacities for independence which exist in very young children.

Similarly, assumptions which are made about the aged, and the value placed upon the sense of "being needed," may also be set aside by those who accept aging as a normal part of a continuous process in which physical usefulness is extended as far as possible, and its diminution is accepted as a matter of fact. The focus upon the practical circumstances which surround the various stages of growth and development may have far more meaning: i.e., adequate food, shelter, clothing and the resources for pleasure will be recognized as the desirable basis for security at all stages.

The presentation of material in a conventional context has an additional disadvantage: it tends to imply invidious comparisons, i.e., concepts of "the culturally deprived" versus privilege; and the "poor" versus the "not poor," and to close off channels of observation and communication. The trainee who concludes that what is taught about the basic needs of children or adults, what is valuable

about the uses of experience in stabilizing dependency-independence, and the importance of the personality and life experience in individual reaction to illness and other crises, is valid only for "them" rather than common to all, will lose the single resource which will make understanding constructive: access to self knowledge as a means of understanding others.

For these reasons, material which is presented throughout the training period will have meaning if it is closely related to the experiences of the trainees themselves; if it draws upon observations and reactions in the course of practical application in the training period; and, by moving from particulars to concepts, establishes a less personal comprehension and tolerance which becomes the supportive resource in the service program.

In the course of her employment, the homemaker/home health aide working in the home will have a more intimate and continuous contact with the family and the individual than anyone else in the team. She will be exposed to the irritation of those who, having been independent, resent the imposed necessity of having strangers intrude upon habitual privacy; to the hungry demands of the fearful and insecure whose defenses have been diminished or destroyed by illness; to the resentments of children unwilling to accept a substitution in those who habitually cared for them; to the displaced dislike of those who detest their disabilities; to the guilt and hostility of healthy members of the family group who must tolerate the changes brought about when illness destroys previously existing family relationships; and to the complaints, magical wishes, needs, and despair which may accompany crises. She will also experience the rewards that come from understanding and supporting the almost unlimited capacity for adjustment, adaptation and growth which exists in human beings.

Concepts Basic to Understanding and Tolerance

If she is to achieve the necessary understanding and tolerance, her training must begin to develop along basic lines which are common to almost everyone:

1 The recognition that the reactions or behavior which she may experience or observe will not necessarily be related to her personality, capacities or work, but to the situation which exists and seemingly cannot be dealt with in any other way by that individual at that time.

2 An understanding that all behavior has a purpose in the personal economy of each individual; that it has meaning and is usually a way of adapting or adjusting. Thus, it may be *seemingly unacceptable* and still *serve a constructive use*, as in the increased childishness which is often a component of illness,

and is a way either of accepting help, or of mobilizing resources. It may, even when destructive (in terms of achievement of a better state of physical or emotional health), seem to serve a purpose in individual terms, and may be understood in those terms (and frequently must be if it is to be modified).

3 Acknowledgement of individual differences in reactions to similar circumstances (and this will take considerable demonstration) so that it is not safe to assume that *what one individual needs* in periods of stress will be exactly the same as what the aide might need in that same circumstance—to be "cheered up" means different things to different people—and indeed "cheering" may not serve the purpose at all.

This awareness of difference and the necessity for observation of the ways in which others respond, replacing the aide's desire to achieve personal satisfaction from the "cheering" process, is probably the most important temperamental characteristic in a good aide. Fortunately for this process, a natural common sense "wait and see" reaction is frequently present; and this can be built upon.

Finally, the trainee must be brought to a realization that the ways in which people react are not only personal to them but the product of *a particular life history;* of the kinds of parents they have had; of where and how they grew up; of what they have always found useful in behavior; and of their habitual reactions to stress or their relationships to others. Certain seemingly imcomprehensible relationships or behavior patterns will be brought into the discussion by the students themselves, as in discussions of a long standing marital relationship based upon strife. The realization that this is the way in which relationships themselves have been experienced throughout life may be viewed with dismay, but with understanding there will be less readiness to say "They should be separated . . .," after 50 years of just such a relationship.

Normal Human Growth and Change

Training content in normal physiological growth and change should stress the fact that norms are flexible and allow for individual developmental patterns. It is important for the trainee to understand variations in the developmental range so that she does not fall into attitudes of concern when children do not sit, stand, walk or talk "when they should" according to her understanding; *she does not make comparisons* with her own or other families she is serving. Food habits or ritualistic behavior patterns in children at certain ages, and seeming regressions at certain developmental stages or during stress (bed wetting,

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blanket sucking, sudden attachment to a ritualized food pattern), should be understood as normal behavior.

Differences in the rate of maturation should also be stressed. It is essential that the trainee's personal responses to the development of sexuality be carefully evaluated with considerable emphasis in a healthy matter-of-fact approach. Confusion, misunderstanding and myth are common in the population in general. These include convictions about bathing during menses, masturbation, prenatal "influences." If they are not expressed by the trainees, they should nevertheless be dealt with in the course of developing an understanding of normal patterns of growth and behavior.

Material which deals with aging as a physiological process should be taught with the greatest care. Physical limitations which may be the gradual accompaniment of aging should not be taught with the gloomy expectation that chronic disease, disability and ultimate senility are inevitable. The fact that substantial sections of our population are living into ripe and useful age, and the importance of sound health practices to sustain comfortable function in older persons, should be stressed.

Essential Needs at Various Stages of Life

The essential needs of people at various stages of the life cycle, factors which affect emotional health and maturity and which influence personal adaptations and adjustments, may be presented in an organized sequential form. These may be related to sessions in which the physical characteristics of growth and development, physical health, and illness are being taught. They may be related to what is being taught in practice sessions. Particular phases may be developed from material brought from on-the-job experience. The greatest stress should be placed upon the interrelationship of all life experiences. It should be understood that the child is always present to some extent in the adult; that emotional factors in physical illness and well being cannot be separated; that developmental stages produce characteristic behavior patterns which cannot be viewed in isolation; and that absolute illness and absolute health are not usually clearly definable. Even where the emphasis of the service program is to be upon a particular age group, it is important that a general understanding of the growth and development of the individual be taught. The adult will be better understood if he is not considered to have appeared full blown as a "sick old person" without a past, and the child will be considered in terms of how well he may be expected to cope with adult life if the influences present in childhood are effectively understood.

The material presented should include:

the needs of infants, how the sense of security is established, and how the ability to establish relationships to others begin; the pre-school child and how he begins to understand and deal with the physical world; the frustrations and satisfactions which develop with growing mastery of himself and his environment; factors which interfere, such as illness or disability or the disruption of his security through grief, separation or the inadequacies of those who cannot meet his needs, and the ways in which he may be helped;

the school age child; socialization and the growth of independence;

the adolescent and the conflicting pressures of growing maturity; the fluctuation between the desire for childhood and the desire for independence; illness and disability during these periods and their effect;

the young adult, marriage and the assumption of responsibility; pregnancy and the conflicts and apprehensions which may affect the willingness to accept the responsibilities of parenthood; coping with the responsibilities of economic independence; the marital relationship and the influence of different life experiences on adjustment; "mothering" and "fathering" children;

the relationships of children to each other in the family group and their influence in other relationships; and

"growing old," maturely.

CHANGING ATTITUDES TOWARD AGING

There has been considerable increase in homemaker/home health aide services provided to aging persons, and for this and other obvious reasons special emphasis on attitudes toward aging is important.

This is a section of the training program which will require an expansion of vision and knowledge if constructive methods are to be developed. In a culture which has devoted the most careful attention to the physical and emotional needs of children, and to the "preservation of family life" (i.e., marriage, and the promotion of a healthy environment for the growth of its future citizens), there has been surprisingly little real exploration of the condition, needs and characteristics of its mature population until recently. Much that has appeared in the thinking and writing of our time has had very little to do with reality. Perhaps this is because a good deal of what we are taught and what we

teach is lifted uncritically from material which may no longer be valid; which may have been based upon narrow experience; or which is filled with cliches and conventional concepts that are transferred usually because they are easily transferable.

In *The Psychoanalytic Study of the Family,* after the most extensive examination of the conditions which lead to true maturity, Flügel explains that in the animal world and in many primitive communities "there is no thought or care or tenderness devoted to old age." He points out that "at least some degree of attention is given in all civilized societies to the needs—material and mental—of those no longer able fully to support themselves or carry on their life without assistance" as a result of "the increasing moralization of human character—." (*1*) He then describes the character and assigns the role of the aged:

> "The old tend always to live to some extent vicariously: they find a great part of their interests and their pleasures in the doings of others who are younger than themselves: their own lives are projected into those of their children and their grandchildren, and by means of this projection they enjoy the most natural compensation for the decline of their own personal interests and capacities. If they have found this compensation, it may well be said that life's concluding chapter has shaped itself for them in a form as satisfactory as any which it is granted to human nature to enjoy" (*2*).

This firmly establishes one stereotype which has achieved a common and comfortable acceptance: the white-haired grandmother, complete with smiles, shawls and rocking chair, allowed "moralistically" to live, rather than allowed to die without care. Then, based upon another extreme—upon experience acquired primarily from institutions for the aged such as the chronic disease hospitals, nursing homes or from back rooms where neglect, sensory deprivation and genuine ignorance have accelerated deterioration—we are provided with a different understanding: that the aged person is forgetful, irritable, no longer feels needed in job or family, cannot accept change, lacks motivation. He is physically decrepit, with vision, hearing, circulation and balance impaired, and joints deteriorated, along with a host of other miseries and limitations.

Viewing the Aged Realistically

The disservice which we do to our culture, our understanding and in consequence our planned measures for the provision of services to older people when we present these stereotypes is immeasurable. Programs providing services to the aged and

chronically ill in their own homes can testify to the fact that, for every "unusual" functioning septuagenarian, octogenarian and even nonagenarian celebrated in the newspapers and slick magazines, there are hundreds who are equally alert and capable of enjoying life at home. They may not be Chaplins, Maughams or Schweitzers because their endowments have been different; but within the framework of their lives, the capacities of a personally satisfying and dynamic experience in maturity are equally present. Physical limitation need not imply intellectual and emotional limitations, and the instructor who approaches aging with the attitude that at a certain point in time there is a sudden collapse into senility, uselessness, hopelessness and unremitting physical discomfort, will not be preparing the trainee for reality.

In general, the problems which confront the older person in need of services at home relate to the circumstances of chronic illness, an attendant fluctuation in physical mobility, and, as a result of these, breakdown in the ability to manage or have access to the essentials necessary to optimum functions; i.e., regular and adequate medical services and other therapeutic services, a clean environment, good nutrition, and an attentive approach to what has been the pattern of sensory, emotional and intellectual stimulation in the past so that these can be supplied through alternate or supplementary means. Not every adult has raised a family; not every adult has had work which was so satisfying that he feels unwanted or not needed when he is no longer performing. He may enjoy leisure in his own way without benefit of a job he did not like. Not every adult has needed to feel himself a part of a group. Some couples are pleased that their children are grown and are satisfied with a quiet life together. They may thoroughly enjoy the release from the necessities of parenthood, or even grandparenthood, and far from securing their satisfactions "vicariously" from the young, burn with anticipation to follow interests and pursuits long deferred because of previous responsibilities. Not all lone individuals, having reached an advanced age, feel "shut out" of social contact if group activity has never been a way of life for them. Limitations in physical mobility are not punishing to those who have never enjoyed tennis or walking; who have formed a lifelong sedentary habit.

Even those situations which may, at first glance, appear to be destructive are not necessarily the product of mental or emotional deterioration. Two older sisters, or an older mother and daughter, may live together in what may seem a dull or even strife-ridden relationship, but this may be the relationship which has endured and which for them has been a way of life—it may be what constitutes security for them; the absence of the physical necessities

which must maintain it are what is disturbing. Husbands and wives, who have established a way of life which to the outsider appears impossible in terms of emotional health, may be continuing what has been established in early life—a relationship which has in some way produced its own satisfactions: it is the necessity to change that way of life because of physical or economic disabilities that is threatening. The fact that these people turn away from what society thinks is good for them is therefore not necessarily evidence of senility, deterioration, or being "set" in their ways because of age. It may be the continuation of a strong individual response, and should be accepted as such. The depression which may be observed is often a reaction to increased and frequently modifiable external circumstances.

Preparing Trainees to Work with the Aged

In preparing the trainee for work with older people, therefore, the emphasis should be, as it is with any other age group, upon understanding the individual and his way of life. Arbitrarily, it should be established that no mature individual is to be treated like a child simply because of his physical incapacity, and this may be difficult to do if professional practice which sets the example considers the bed to which an adult may be confined as interchangeable with a child's crib. Stereotyped methods and practices adopted as a means of alleviating isolation, depression and loneliness should be carefully re-examined in terms of individual needs. Neither the program nor the trainee must assume that a general approach can be made to individual situations in aging any more than it can in any other stage of individual life history. An attentive approach to what is characteristic and personal, and a sensitive adaptation to these, will be the best methods of avoiding or arresting those alterations in personality which are so frequently described as characteristic.

Additionally, the emphasis upon minimizing or improving physical limitations—food, light, warmth, cleanliness, and other essentials which maintain the human self-image and which do break down when physical capacity is impaired—may perform some of the marvels hoped for from stereotyped approaches by providing a framework in which the adult can continue to function as a person in his own way.

PRACTICAL KNOWLEDGE AND SKILL

Personal care

The duration and scope of training for personal care services will depend more than any other area of training upon the objec-

tives of the employment program and upon the quality and quantity of the professional supervision available throughout the provision of these services. Whatever the program is to be, however, it cannot be safely assumed that what is taught in the basic training program will continue to be effective unless it is constantly reinforced and supplemented on the job. The reactions of the trainees, confronted with the actuality of providing personal services, will range from apprehension to eagerness and overconfidence, and both extremes will require a methodical program of supervision in order to bring the skills which are taught into a clearly defined area where they can be safely performed.

For this reason, the first essential in beginning this aspect of training will be to instill in the trainee the importance of relying implicitly upon the supervisor for direction concerning the tasks that are to be performed in each case. Where there is insecurity about any aspect of the service, the trainee must be encouraged to ask for help; where there is overconfidence, firm limits must be set, and the importance of staying within these limits stressed. In the course of training it will become apparent that certain trainees may never acquire confidence and skill in some activities, and this must be carefully noted so that assignments are made within the limits of the trainee's capabilities.

Understanding the Body and its Functions

It should not be surprising to discover that the trainee's knowledge of the body and its functions may be lacking, incomplete, or based upon misunderstanding. A simple review of human physiology will be a sound basis upon which to build.

From the description of normal bodily functions, the variations and deviations from normal bodily health may then be discussed, and here the relative aspects of health and disease should be emphasized. Although detailed diagnostic information is neither necessary nor desirable, discussion will soon reveal limitations in understanding and misconceptions about illness which must be cleared away.

For the uninformed a diagnosis related to "heart trouble" will bring out the conception of one who must remain quiet, never climb stairs, and perform no unnecessary movement "for fear of a heart attack." Stroke, "to be paralyzed," will frequently be understood as a static and unmodifiable condition; in some cultures tuberculosis, even when arrested, is seen as far more malignant than cancer. On the other hand, "a little cold," even in the presence of severe cardiac disease, is seen as an isolated minor illness having no relation to the major problem. Disabilities related to movement, whether in children or adults, may evoke profound

sympathy along with the passive acceptance that "crippling" cannot be modified. In general, the discussion of variations from normal health should be presented in such a manner that they are seen as usually fluctuating, and relative rather than absolute; and treatment objectives presented in terms of achieving the optimum in physical comfort and relative health at all stages.

Certain general frequently used terms may be explained and illustrated: what is meant by "absolute bed rest," "convalescence," "absolute bed rest with bathroom privileges," "semi-ambulatory," and "ambulatory."

Making Observations

Observations which may be made by the trainee and which signify deviations from health should be described. The nature of these observations have been excellently outlined by a physician who has worked with home health aides:

> "Now what are the physical evaluations I think a home health aide should do. Remember, most of the professionals that go into a home are there for a very short period of time. A nurse can go in and may be there for 45 minutes; a social worker for 30 or 45 minutes; the physical therapist for 30 minutes to an hour. This may be on a very piecemeal basis. Most of the home health aides are there over a longer period and I think one of the problems of why the physician has been distrustful of some of the home health services has been the lack of valid long-term observations. I believe the home health aide can do some of these observations.
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> "Let us go into the physical things. What would I want a home health aide to do? 1) I would like to know, for example, if the patient is complaining of pain. The aide is not going to treat the pain, but she can help me to know how long the pain lasts; what effects does medication have on pain; what appears to bring the pain on; what effect, if any, do family relationships have on the duration of the pain—on the onset of pain. These observations that can be made and frequently could best be made by a home health aide, perhaps far better than anyone else. 2) Or let us take the appearance of shortness of breath, for example. Is it associated with a cough? Sometimes patients cannot give you this information. How does it occur and when? What appears to relieve the cough? Does sitting the patient up help? 3) Then there are observations concerning the gastro-intestinal system. How does the patient eat? The nurse may or may not be in at this time of the day to see this. What are the types of food the patient seems to enjoy; is the patient able to swallow these foods

fairly well; are there any abdominal complaints that are brought on by this? 4) The genito-urinary system: the frequency, effort and ability to control the urine. 5) Palpitations: the home health aide could become quite competent at taking a pulse—we expect patients to do it. Frequently the patient will develop a pericardial rhythm and by the time a doctor or nurse gets there this rhythm may be gone, but if someone were there to get that pulse they could tell us very rapidly how fast it was and was it regular or irregular—that is all we need to know. This can make a diagnosis possible—the patient can have angina pectoris during the rhythm and no one is there to identify it. These are things I think any normal, reasonably intelligent person can do—it doesn't take a college education—the average intelligent person can do this type of thing.

"The last thing I want to discuss is the mental status. Again, what are the significant observations? Is the patient easily excitable; is he withdrawn or alert to his surroundings? How does he communicate? Does he recognize people regularly? Are there periods when he does not? and what influences this. Is he able to keep up with current events? What is the span of attention—things of that nature" (*3*).

The Care of the Sick

This may well begin again with sanitation. The ways in which disease may be communicated may be more specifically discussed, and from this the necessity for frequent hand washing before and after handling the patient, and before and after handling food, will be more clearly understood, as will the necessity for similar practices for the patient. Demonstrations will repeat what was learned in orientation around care of utensils used, the methods of maintaining a clean bathroom and kitchen, the handling and disposal of soiled linen, and disposable material used by the patient.

In the course of training, the particular sequence in the development of personal care skills will depend upon the preference of the instructor, the basic aptitudes of a particular group of trainees, and perhaps the availability of the specialized setting necessary for demonstration and practice. Some instructors, for example, consider that bathing the patient in bed is more complicated than assisting with tub baths and showers. Others consider that when a debilitated or frail individual is involved it is difficult to choose between the two. In any case, the content of training for personal care will best be taught if it is linked in some kind of sequence building from the simplest tasks to those which appear to be more

complicated for a given group of trainees and when it is similarly linked in a logical sequence, such as patient comfort, or the movement from illness to convalescence, to complete functioning.

Summary

In general, personal care training will be based upon the objective that aides will have a general knowledge of bodily functions; they will be capable of making observations about the daily changes in the physical state of the patient; and they will be able to take temperature, pulse and respiration. They will be competent to help with feeding, to make a bed with or without the patient in bed, and to safely perform transfer activities from bed to chair. They will understand the necessity for good position both in bed and in a chair. They will be able to bathe a patient in bed or assist in bathing in the bath or shower, help with toileting, using bed pan, commode or assisting the patient to the bathroom. They will be able to help with personal hygiene, assisting with care of mouth and teeth, shampooing hair, shaving, and they will maintain an atmosphere which is clean and in which the basic sanitary practices of the sick room are consistently observed. They will have some knowledge of simple sick room equipment and its use; that is, they will understand how to use a wheelchair, how to move a patient in and out of the tub using grab bars or bathing stools, and will at least have had some familiarity with other more specialized equipment.

References

(*1*) Flugel, J. D., *The International Psychoanalytical Library, No. 3*, The Hogarth Press Lit., London, 1960, p. 240.

(*2*) *Ibid*, p. 241.

(*3*) Alex, Morris M.D., *The Physician and the Home Health Aide*, presented at the Institute on Training Homemaker/Home Health Aides for Community Service, sponsored by USPHS-OEO, Jewish Hospital, St. Louis, Missouri, August 30–31, September 1, 1966.

CHAPTER 12

Teaching Methods

PERSONAL CARE

The methods for teaching homemaker/home health aides personal care skills have been aptly described by Esther Gilbertson (*1*). She says, in part:

> "Just as there is no book that will tell you what to include in the basic training, there is none that will tell you how to teach it either. Personal care is task-centered, and involves manual skills, the use of hands; so it can really only be taught by demonstration, practice and discussion. Fortunately these are the ways that adults learn best—by practice, demonstration, and discussion. Most of the information needed by the aide in performing personal care—in terms of knowledge of body function, knowledge of personal hygiene, knowledge of various other factors—can be taught during demonstrations, and practice, and reinforced by discussion. Most of these facts when taught at this time and in this way will relate very specifically to the procedure and the aide will be thinking of facts as they relate to what she does. For example: In teaching the aide how to lift a patient; how to get the patient out of bed, body mechanics for both the aide and the patient can be made more meaningful. The care of the skin when related to infection and personal hygiene is more apt to result in regular handwashing practices. Adults learn in terms of their interest, and accept information that is going to be useful to them.
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> "There is no teaching that requires as much planning on the part of the instructor as demonstration and practice methods. It is first very important to find out all you can about your prospective students. Know what their educational level is and something about any previous work experience. Then start to adapt your teaching method.
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> "Remember that taking care of a patient involves one kind of skill: teaching these same tasks to someone else is another kind of skill. For some people teaching is easy but for most it requires painstaking hard work on the part of the instructor.

Plan very carefully how much you are going to put into one lesson. You may not be able to gauge the amount of time needed for the first lesson because you are getting acquainted with the group, but soon you will know that only so much can be taught in one lesson. All the skills to be learned in personal care are manual and will need to be practiced and practiced until they can be done safely and skillfully. The safety factor should be the primary consideration. Skill contributes to safety but comes with having done a procedure many, many times. The most useful hint I can give to those of you who are teaching for the first time is that you break down the demonstration or procedure into its smallest units and practice it in these units.

"Identify in each demonstration the principle you want the aide to learn. A basic principle is safety and another is the comfort for the patient. It is easy to get involved in activity that obscures the important principle to be learned. As you plan, consider the vocabulary so that you remember to explain what the words mean. Most of the time it is good to start with something that is very simple, but sometimes this is not true—sometimes it is better to start with something that has a special challenge for the group. For those who are new to teaching I would suggest that you practice the demonstration. It is very helpful to know just how you are going to do each step of the procedure and how to explain it.

"You will have the responsibility of deciding whether the aide is going to be capable of giving personal care. In evaluating the aide's ability a first consideration is the purpose for which the homemaker/home health aide is trained. She is trained to work in a home and provide much the same kind of care that a member of the family might provide. Secondly, that she is going to be supervised by a nurse in the activities she will perform. The expectations for the aides should not be in any way compared with a student nurse or practical nurse. The aide is not being trained for the same purpose. It is better to evaluate in terms of the progress she made and her potential for development. Annotate your observations as you go along. In evaluating her ability, the first consideration is: can she do the procedure safely? Did the procedure accomplish its purpose—was the patient left comfortable? Finally, did she consider the patient as a person?"

As Gilbertson's discussion makes clear, much of the homemaker/home health aide's training will be related to the care of the adult, the disabled, and the chronically ill. But time and practice are usually provided for the care of sick children and, where the pro-

gram intends to make use of the aide in infant care, for bathing and physical care of infants.

During the early phases of training, it will become apparent that all of these activities are undertaken with the most intense concentration upon the physical task. The patient becomes an object to be moved and manipulated in accordance with instructions. Humor (never ridicule), reassurance and ample opportunity for repetitive practice without the implication that the slow acquisition of skills means limited capacity will be the best assurance that later practice will be safe. ("I guess I'm just *dumb!*" says the exasperated trainee again and again. "No, you're *not* dumb!" says the instructor, "It looks easier than it really is because I've done it so many times.") But skills which seem shaky at the end of this basic period should be carefully noted and eliminated from the aide's assignment. They may be attempted again at a later time when the aide has been brought in for a "refresher session." By then, she may have gained greater assurance in other phases of her work and be more confident in her attempts to try again.

Throughout the course of this phase of training—as in all its aspects—the *purpose* of each activity in terms of patient comfort and well being will be the best way to maintain interest in precise performance. The trainee who cannot develop precision in making a tight bed when it is empty will feel differently when she first sees a bedsore. She will think back to her instructor's words when she comes into the home for the first time and sees a hot, sticky, fretful man or woman, or a restless child, unkempt and unhappy. Her natural instinct will be to remember what she has been told about light, air, room temperature and clean skin.

She has been helped to understand the important part that an attitude of assurance, calm and strength play when she approaches a new patient who may be fearful and uncomfortable, through constant emphasis on the fact that this is a real person, to be approached with sensitivity. Role playing which will encourage the trainee to talk to the patient will be helpful, and she must be taught to allow him to assist where he is capable and always to make certain that he is permitted to remain an individual. His probable fears and apprehensions can be described and discussed, and ways of meeting them without infringing on personality, dignity and privacy can be demonstrated.

Where training and field practice take place concurrently, the trainees will of course bring to the training sessions their difficulties and experiences, and invariably the discussion of the various diagnostic states will be brought up. The instructor may begin to gradually build on the information which the trainees have gained

and ways in which trainees use this information will be a good indicator about the selection of certain of them for later specialized training. Where there is an eagerness to use technical terms rather than to focus upon practical evidences of need for care, the instructor will be most helpful if she assists the trainee to rechannel her interests into those ways in which she can genuinely observe, report accurately and in plain language, and be of help in increasing the patient's comfort. Those trainees who are quick to realize this as a value, and who relate these aspects of their work to a particular illness or set of physical circumstances, will be best suited to move along into training for more complex skills.

NUTRITION, MEAL PLANNING, FOOD STORAGE, MARKETING

The basis of a good diet will best be understood if it is related initially to the trainee's own experience. Indeed, unless it is presented in this manner, there will be a tendency to learn by rote what "nutrients" are, the importance of "basic" foods in the daily diet, and something about "calories" and "vitamins" (known primarily through misinformation and advertising). The real understanding necessary for the application of what is learned must be acquired, and, what is more important, that flexibility which will lead to an ability to adapt learning to individual patterns of living, must be understood in relation to individual tastes and habits.

Some programs have found that when they have emphasized the teaching of nutrition in technical ways, they have made good cooks uncertain and self-conscious, primarily intent upon producing the recommended "nutrition" rather than an appetizing meal. They may have achieved an excellent personal style of preparing appetizing food at home. But in their work assignments, they will sadly arrange the broiled and boiled—the proteins, carbohydrates, fats and vitamins—on a plate, serving them up with silent commiseration to the poor sick folk who must have a "balanced" diet instead of a decent meal. The importance of food as a source of pleasure, its presentation in a harmonious, relaxed atmosphere, as evidence of the care and comfort which it represents in addition to the pure function of providing nutriment will be readily understood, and new information will be accepted if it is based upon the firm foundation that food is first of all a matter of individual taste and for individual satisfaction.

The essential concepts upon which the content of training in nutrition are based on these:

Nutrition is the food we eat and how the body uses that food.
Food is made up of different nutrients needed for health and growth.
Everyone, throughout life needs the same nutrients, but they may need these in varying amounts.
The way food is handled affects the amount of nutrients in food. It also affects its safety, appearance and taste.

The discussion of personal attitudes toward food, personal food habits, the family atmosphere and taste as it centers on food and meal times must be used to illustrate the ways in which individuals, families and cultures differ. The challenge, both to instructor and trainees, will be to attempt to use these differences rather than eliminate them.

During the course of discussion with trainees, every effort should be made to bring out, evaluate, and eliminate certain myths, superstitions, biases and fads which will be as prevalent in this group as they are in our general culture. The instructor will uncover notions about food combinations—that cucumbers and milk are "poison"; that it is necessary to wait two hours after eating cherries before using any dairy product—as well as ideas about the therapeutic properties of certain combinations. Beliefs that certain foods are a cure for specific diseases (celery as a "tonic" for arthritis and carrots for poor eyesight), the common assumption that grocery store vitamins are a sure, all-purpose cure must be reviewed in an objective way which contains no element of ridicule, no implication that those who have adhered to such beliefs are ignorant, foolish or stupid.

Such misunderstandings and misinformation about foods and nutrition must be cleared away so that the aide will not, consciously or unconsciously, allow them to affect either her practice or her attitudes as she prepares and serves food. She will encounter many of the same prejudices and biases—and a good many more—in the course of her employment. The aide should understand that nostrums for "tired blood," unprescribed multivitamin and mineral supplements, innumerable rituals, prohibitions and compulsions about food should, when encountered, be treated as a part of the individual's personal pattern. She should understand that she is not expected to interfere with these; she will observe and report them. Any alterations or modifications are to be undertaken only on a planned basis.

Against a background of tolerance and flexibility, the basis of good nutrition may then be taught, with suggestions along the way for adaptations to personal taste and habit. Basic training has the objective that the aides will have an understanding of the concept of a balanced diet; the food needs of infants, young

children, adolescents, pregnant women, working men and women and the elderly. Meal planning practice should take into consideration certain individual habits or limitations; the dislike of young children for certain slippery or gristly foods, problems of older people with dentures, and the "finicky" eater. Along with meal planning, suggestions for preparation and serving may be presented with emphasis upon preserving nutrients. Recipes and suggestions about regional or personal tastes should be included. These will frequently be suggested by the trainees themselves. Demonstration meals should place special emphasis on color, texture, flavor and attractive table and tray setting.

Special diets are preferably taught by a nutritionist, and the trainees become familiar with those which can generally be described and demonstrated (bland, low caloric, etc.); but the basic training program may not include great detail with respect to those which must be carefully controlled. Meal planning for the diabetic patient, for example, may be generally described but will usually best be taught under supervision on the job around the needs of individual patients. (Information of this kind tends to slip away unless it is constantly used).

Marketing for food should be taught with practice in marketing for families of given sizes for specific periods of time. When employment is to be in the homes of older persons, quantity cooking is not always the most economical. Emphasis in child care is usually upon quantity marketing and food preparation. As much emphasis should be placed on purchase and preparation of foods for the family composed of one, two or three adults. Such families may be unable to consume a large casserole by feeding on it monotonously day in and day out, however economical this may seem in the food budget. Adults, unlike children, frequently will prefer to miss a meal rather than subsist on an unvaried diet.

Although the purchase of food in season where it is highest in quality and lowest in price should be stressed, for the small family where there is illness, emphasis upon variety and interest is sometimes most economical and more productive of appetite. Since the trainees themselves may be most accustomed to shopping for the larger family, stress upon information concerning appropriate quantities for adult families of smaller size will probably be helpful.

Storage of food should include information concerning handling, temperature, containers and wrapping, moist or dry storage, the maintenance of freshness and palatability in varying circumstances (i.e., inadequate equipment for refrigeration, the presence or absence of a freezing compartment, or of a refrigerator). It should especially stress the types of spoilage which are dangerous

to health. Custards, puddings and similar soft foods using eggs and milk are frequently a part of the diet of older patients, and proper conditions for preparation and storage of these should be carefully taught.

Household Management

This will include principles of household management; the use of equipment and supplies; acceptable substitutes; and planning and organization of household tasks.

Although many of the families to which the aide goes will be small, she may be providing service to two and in some instances, as many as three households during the course of a single day's work. For this reason she must understand the stress which is placed upon the organization of her work. The development of work habits which will save her energy are her best assurance that she will continue to function effectively.

She may initially resent, but come to appreciate the instructor's emphasis on comfortable garments that fit and do not pull or bind. Although she may have earned at least a partial living at "day work," she will probably have relied on sheer strength to get through the day and may never have considered the ways in which method may relieve physical stress. Such methods will appeal particularly with older aides who are apprehensive about their ability to perform consistently if some housework is to be a part of each assignment.

Training in method will have its best effect if it emphasizes the techniques of work simplification:

Learning to organize work which can be done while seated rather than in constant up and down movement.

Using a foot stool, a box or the rungs of another chair while working at tasks which can be performed in a seated position.

Learning to bend the knees rather than the back.

Learning to plan work within each circumscribed area rather than walking back and forth.

Shifting position rather than standing too long or sitting too long. Changing the tempo of work.

Planning the day's schedule so that only one of the major tasks is done each day (i.e., so that all of the week's vacuuming, or laundry, or shopping for all families is not done on one day).

Learning to rest briefly but frequently.

Developing the habit of working in a relaxed frame of mind without worry about the next assignment or the previous assignment.

It will be important to stress the fact that each individual

does work at a different speed and that some assignments will take more time than others. The aide who must take great care in preparation of a meal and who is going to take the time to chat with a patient during the course of the assignment should still be able to work without tension. If an adjustment of the assignment is necessary, she should feel secure enough to report this so that proper action can be taken.

One of the important elements in teaching household management will also involve emphasis on the family's usual way of doing things or the gradual introduction of new ways. Equipment and utensils should be replaced so that they are available to the family according to family habit rather than for the convenience of the aide. (Particularly with older people, the maintenance of a sense of security is based upon knowing that things will be where they have aways been). Where the aide is assisting in the development of work simplification patterns for the patient as a means of saving energy, this should proceed slowly, and without a flurry of reorganization which may confuse or unsettle.

Summary of Core Training

This is the period during which the aide learns what is essential to provide the necessary services in the home. It is intended to provide the aide with information concerning those with whom she will work and her relationship to them; to provide information concerning the various services and resources in the community which may be also active in planning and providing services to the families in her care; to enlarge her understanding so that she can become a helping person to the various types of people she must serve, many of them in stress situations; and to teach her the necessary skills so that she is able to maintain personal comfort, optimum nutrition and a clean environment in the home for the families to which she is assigned.

The approximate time suggested for basic training is 70 percent of the total training time.

"REFRESHER" AND SUPPLEMENTARY TRAINING

Since training must be considered a constant process, the period immediately following core training will give both the supervisor and the aide an opportunity to test out what has been learned. As each new assignment is undertaken, the ability of the aide to apply what has been taught should be evaluated and supported. This may be accomplished by demonstration on the job, conferences, and discussions, both individually and with small

groups of three or four aides, of their experiences, difficulties, and achievements. It will be found that, with encouragement, the aides will help one another, often contributing simple ways of dealing with new problems.

Certain of the more experienced aides develop great skill in communicating in this way, and the inclusion of an experienced worker with a group of new trainees in these discussions adds a good deal of support, coming as it does from the practical, "Well, I usually do it this way," or "What I say is this. . ." approach.

"Refresher" Training

During the course of the closely supervised work experience which the trainees will have following their basic training, the supervisor will have an opportunity to evaluate the training program itself. Commonly, it will be discovered that since every session is not necessarily as successful as every other session—and this need not be a reflection either upon the planning or the instruction—there will be certain aspects of practice which are observed to be weak in the course of application. In some situations, it will be the bed bath that individual aides or a group of aides have not learned to give comfortably and efficiently. In others, it may be that a group of aides has not accurately learned to take a temperature, and in still others it may be that three or four aides are still awkward in transfer activities or have forgotten what they learned about positioning. Where this is the case, groups of aides, three or four at a time, may be brought in to review the essential routines. Many programs routinely schedule such "refresher" courses for each group of aides at least once a year.

Supplementary Training

When it has become apparent that the basic performance of the aides is acceptable, those agencies which plan to extend their programs will begin to think in terms of building onto this basic knowledge and producing at least as part of the agency's staff a group which can undertake more complex responsibilities. Supplementary training may be carried on in a variety of ways:

The training may be organized as a part of the regular on-going educational program of the agency by maintaining throughout the year a series of periodic special lectures or sessions based on a long range plan to increase knowledge.

"Spot" intensive sessions may be planned comprising one, two or three day institutes for special purposes. This might be a three day training program in a rehabilitation center, in a child health conference, or in a chronic disease ward. It might focus on the use of specific equipment such as the use of lifts and walkers. It

might present a program around a specific area such as teaching child care, or "Strike Back at Stroke," in order to develop the ability to teach parents, or work simplification or to develop lost physical skills in convalescing individuals. It might involve training under the supervision of a physical therapist with special emphasis on arthritis; the needs of the cancer patient and the diabetic, are others of special interest. A group of intensive sessions may become necessary in order to serve groups of patients who require special diets: i.e., the diabetic diet, the low sodium diet.

A series of sessions may be planned over a limited period of time, perhaps two hours a week over a period of six weeks, to develop understanding and skill in the care of persons with drinking problems, mental illness, and mental retardation. Or, the training sessions may be designed to develop a core of personnel for new community situations: assignment to outpatient clinics, assignment as community health aides, assignment as physical therapy and occupational therapy aides.

In each case, the basic principles in training will be most effective if they are planned with concern for the essential needs of the group. Even at this period, didactic or academic approaches should be avoided. The sessions should be brief, practical, and presented in plain language. Material should be presented, reviewed, and reinforced, as they are in the "core" training.

SUMMARY

In summary, training of homemaker/home health aides will be most productive, if after careful screening and selection of trainees, the following situation prevails:

1 Training is conceived of as a continuing process.
2 Training is planned in relation to the program of service which is anticipated. The knowledge, aptitudes and skills necessary for these services are given proper emphasis in the plan for training.
3 The content of the material which is presented is related to the capacities of the selected group, and is so designed that practical skills and knowledge proceed from those which are simple to those which are complex.
4 Training is placed in a setting which allows for free and comfortable expression.
5 Training is provided with emphasis upon the primary concern for maintaining an open channel to supervision in the interests of good care.

6 Each trainee is given ample opportunity to acquire the necessary skills, and no trainee is expected to assume responsibility in situations or for activities in which her capabilities have not been evaluated and for which she is not adequately prepared.

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